Psychosis and the use of a narrative style approach to therapy: A qualitative study of the experiences of clinician's.

By

Debbie Green BSc (Hons)

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

Coventry University, School of Health and Social Sciences and
University of Warwick, Department of Psychology

May 2006

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Acknowledgements

I would first like to say a huge thank you to all of the clinicians who participated in my research. I really appreciated the time you gave up to talk to me, not only in the interviews, but in numerous emails and in helping me to identify other people who might participate in my research.

I would like to thank my supervisor's for all their support and help in enabling me to complete this project. Thank you to Dr Helen Liebling for her support and guidance throughout this project. I always felt so much calmer after my meetings with you. Thank you to Dr Maria Gennoy for your support and guidance, especially with the empirical papers. I would like to extend a further thank you to Maria for the original inspiration for this project and for this way of working. Meeting Maria is amongst one of the biggest life changing experiences I have had and has enabled me to think critically about how people experiencing mental health problems are treated within society and the mental health system.

I would also like to thank Dr Stephen Joseph for his original guidance in helping me to choose this project and for his support when I was experiencing difficulties in gaining participants for my original research idea. That support enabled me to make the necessary decision to abandon my original idea in favour of this current thesis.

I would also like to thank the rest of my cohort who have been amazing in both supporting those who have struggled and sharing their own experiences of struggling. This enabled me to feel less panicked by what seemed like a huge project. You have been a fantastic group of people and I am really glad to have met you all. I would like to especially thank Sally Bradley, without her support I fear that I may have lost my sanity!

Finally I would like to extend the biggest thank you to my family whose support throughout the years has been immense. Right from supporting my decision to change careers and to go into psychology, up until these final three years where they have had to put up with my roller-coastering moods. I really value your support and don't know what I could have achieved without it! I would especially like to thank my sister for proof reading my empirical papers and for helping me to create a story running through the text.

Declaration

This thesis has not been submitted for a degree to any other university. The thesis was carried out with supervision from Dr Helen Liebling (Academic and Research aspects) and Dr Maria Gennoy (Clinical aspects). My supervisors contributed varyingly to the design of the project, design of the interview schedules and information leaflets, checked drafts of my individual papers and provided validation of my analyses. I organised access to all participants, carried out all the interviews and apart from these collaborations the thesis is my own work. Authorship of any papers from this work will be shared with the above.

Authorship and Publication

See appendix 14 for notes to contributors

Chapter 1: Concepts of 'the self' in psychosis: a review of current literature and the implications for clinical psychology

This chapter is being prepared for submission to the British Journal of Clinical Psychology (Green, Gennoy, & Liebling, 2006)

Chapter 2: The use of grounded theory to explore the experiences of clinical psychologists using a narrative approach with adults who experience psychosis

This chapter is being prepared for submission to the British Journal of Clinical Psychology (Green, Gennoy, & Liebling, 2006)

Chapter 3: The use of Grounded Theory to explore agents of change in a narrative style of therapy with adults experiencing psychosis

This chapter is being prepared for submission to the British Journal of Clinical Psychology (Green, Gennoy, & Liebling, 2006)

Chapter 4: The roles of 'medical models' in the treatment of people who experience psychosis

Summary

The purpose of this study was to investigate the use of Narrative Therapy with adults experiencing psychotic phenomena. The main aim of the project is to identify helpful and unhelpful aspects of the therapeutic interaction. It was found that research into the above topic is quite sparse, especially in the United Kingdom. Research identified has shown that Narrative Therapy can be used, with good effect, with people who experience psychosis. Research has also shown that a narrative approach has been shown to help rebuild a sense of agency and can assist in recovery from serious mental illness. It has been highlighted that more research needs to be carried out into the use of narrative therapy with adults who experience psychosis.

The first paper in this thesis presents a selective review of the current literature around concepts of the self in psychosis. The review provides a critique of the current concepts and considers the therapeutic implications. The second paper is an empirical paper using a grounded theory approach to explore the experience of clinical psychologists using a narrative approach with adults who experience psychosis. The third paper is an empirical paper using a grounded theory approach to explore agents of change in a narrative style of therapy. The third paper is a reflective paper exploring the role of the 'medical model' in the treatment of people who experience psychosis.

Chapter I: Literature Review

Concept of 'the self' in psychosis: a selective review of current literature and the implications for clinical psychology

Word count: 5417 (Excluding Abstract, Tables and References)

Abstract: 170

Prepared for submission to: British Journal of Clinical Psychology

1.1 Abstract

Objectives. Within this review the philosophical contributions to the notion of self, which are relevant in current models of self will be explored. Then some of the current theories and models of self in relation to psychosis will be looked at.

Method. The method utilised to ensure that all of the relevant literature around this topic was found, involved carrying out searches for peer reviewed papers in some of the major databases.

Results. The review will argue that when thinking about the clinical implications of this research the research on the narrative self appears to have more value in terms of clinical practice and on informing therapeutic approaches.

Conclusion. It is clear from the literature that there are many definitions of the self, and probably as many explanations for why the self becomes disrupted in schizophrenia. All of these theories are interesting in terms of trying to understand the self, but many of the theories appear to have limited practical use for clinical psychologists working in the area of psychosis.

Concept of 'the self' in psychosis: a selective review of current literature and the implications for clinical psychology

1.2 Introduction

This paper examines the 'sense of self' in psychosis. When we have a thought we generally know that it is 'us' that is having them. They have a sense of agency, they belong to us. It is *'I'* that is thinking about what I will have for lunch today. I know what I have done in the past and I know where I have come from. We take for granted that we know our thoughts belong to us, but this is not necessarily the case in certain psychological disorders. In psychosis the sense of agency over our experiences appears to disintegrate and people having those experiences can attributed their thought processes to external factors (Kircher and Leube, 2003; Sass, 2003). What could cause this 'sense of self' to breakdown, resulting in severe distress often found in psychosis? Maybe if we can try to understand how the self exists is constructed we can better understand this.

Within this review the philosophical contributions to the notion of self, which are relevant in current models of self will, be explored. Then some of the current theories and models of self in relation to psychosis will be looked at. Much of this research pays particular attention to those who are diagnosed 'schizophrenic', where the breakdown in the view of self appears to be most prominent. There are many conceptualisations and definitions of 'self' (see Zahavi, 2003); however two forms of 'the self' appear to be relevant to the study of psychopathology and in particular schizophrenia. These are the notion of a 'minimal self' (Metzinger, 2000c, 2003; Strawson, 1997, 1999) and the 'narrative self' (Dennett, 1993; Lysaker and Lysaker,

2002, 2005), although these two forms of the self are not mutually exclusive, and both Metzinger and Strawson incorporate both into their theory. Therefore the review will limit its exploration of the self to these two areas. Finally, the review will argue that when thinking about the clinical implications of this research, the research on the narrative self appears to have more value in terms of clinical practice and on informing therapeutic approaches.

The method utilised to ensure that all of the relevant literature around this topic was found involved carrying out searches for peer reviewed papers in some of the major databases. These included: Scopus, Medline(Ovid), PsychINFO, ScienceDirect and searches for papers using an internet search engine. The specific terms that were searched for were: psychosis, schizophrenia, mental illness, psychopathology, self, identity, sense of self, minimal self, narrative self and concept of self. This search was repeated at several intervals to ensure any new literature was highlighted. The results of the searches were screened for their relevance to this project. Then any relevant papers were searched for any other references that appeared to be relevant to the topic of 'self in psychosis'. Throughout this process, the aim was to identify papers that predominantly explored the relationship between self and psychosis, but that also looked at the concepts of self that were currently influencing other disciplines.

1.3 Background to the concept of self

Philosophers across the ages have struggled with the concept of self. Debates have centred on the mind/body dualism. Descartes offered the idea that we have a soul or

a 'transcendental self', that is separate from the body and that will endure when we die. He felt that this 'thinking self' needed no body in which to exist (Hunt, 1994). Hobbes and Locke rejected Descartes notion of an incorporeal soul and state that we can only gain knowledge of the world through our senses. They stated that the 'sense of self' only exists through our interactions with an external world. Hume viewed 'the self' as nothing more than a 'bundle or collection of different perceptions' and thought that it was not therefore possible to discuss the nature of the 'self' (Hunt, 1994). Kant (1781) disagreed with Locke and Hume and stated that we are not born a blank slate or 'a bundle of perceptions'. Rather, he stated that experience provides us with some knowledge about the world, but that it is the structure of our mind, including certain innate abilities, which constructs meaning and not an 'incorporeal self'.

William James (1890) introduced a notion of the self which could be empirically studied within psychology. He claimed that we are all aware of our personal identity, and have beliefs and thoughts that we regard as 'ours'. James claimed that we can access these through introspection and that they can be empirically tested. In order to account for the 'sense of self' James hypothesised a 'pure ego' whose personal identity arises from the continuity in the stream of consciousness.

The concept of the self is again becoming a focus in the literature within philosophy, neuroscience and psychology. This has been especially in connection with some of the more severe mental disturbances such as 'schizophrenia', 'autism' and 'dissociative identity disorder'. Kircher and David (2003) have edited a book on the

self in neuroscience and psychiatry, which is aimed at understanding the role of the self in terms of causal models in schizophrenia. However, it does not look at the role of the self in psychotherapy or the implications of this in clinical psychology. A number of reviews (Gallagher, 2000; Kircher and Leube, 2003; Villagran, 2003) have been carried out looking at the research surrounding the sense of self, making reference to 'schizophrenia' and psychosis. But again, this is with the intention of understanding notions of the self rather than possible therapeutic implications.

Research carried out into the self appears to show that as humans, the feeling of having a whole 'self' seems to be linked with mental well-being. When that sense of self is disrupted or fragmented, as has been shown to occur in migration (Harland, Morgan & Hutchinson, 2004) and in the case of chronic illness (Charmaz, 1999), this appears to result in severe mental distress. Research from the 'recovery' movement has stressed the importance of the concept of the self in psychosis. First person accounts show that it is important for people to have a positive sense of self (Ridgway, 2001) and that recovery involves reconstructing an enduring sense of self as an active and responsible agent (Davidson and Strauss, 1992)

If a disruption in the 'sense of self' plays a vital role in the cause and maintenance of psychotic phenomena, then does it play a role in helping people to regain a sense of wholeness and lead to recovery? With this question in mind this review will explore the current literature on the sense of self, looking initially at models of the self in normal development and then at the research surrounding the self in psychosis. The

review will then try to highlight the therapeutic implications and to explore the research surrounding sense of self and therapy

1.4 Concepts of the self: 'Minimal Self' and 'Narrative Self'

There are many conceptualisations and definitions of 'self' (see Zahavi, 2003). The research that this review will discuss highlights two versions of the self that appear to be relevant to the study of psychopathology and in particular schizophrenia. These are the notion of a 'minimal self' (Metzinger, 2000c, 2003; Strawson, 1997, 1999) and a 'narrative self' (Dennett, 1991, as cited in Thornton, 2003; Lysaker and Lysaker, 2002, 2005). Gallagher (2000) defines the minimal self as: "depending on brain processes and an ecologically embedded body, but one does not have to be aware of this to have an experience that still counts as self experience" (p.15). The narrative self is seen as a "more of less coherent self that is constituted with a past and a future in the various stories that we and others tell about ourselves" (Gallagher, 2000, p.15). Within the limits of this paper it is only possible to provide a précis of these much more complicated theories. However, the texts are referenced if the reader wishes a more detailed understanding.

Metzinger suggests that no such things as 'selves' exist in the world (2003). O'Brian and Opie (2003) state that the idea of a 'whole self' is an illusion created by the brain in order to create a sense of coherence. The self-model proposed by Metzinger (2000c, 2003) comprises three aspects: 1. 'Mineness' or the experience of ownership/agency over perceptions, memories, and thoughts; 2. The experience of selfhood or unity, forming a long-term coherent whole of beliefs and attitudes; 3.

The experience of 'perspectivalness' with conscious states being centred spatially around the body.

Metzinger relates this model to the experience of schizophrenia and proposes the possibility that in schizophrenia, internal speech cannot be integrated into the self-model and is therefore externally attributed, such as appears to be the case with thought insertion and the experience of voices. This idea is explored later in this review in relation to the work of Frith, Rees, and Friston (1998) and Vogeley, Kurthen, Falkai and Maier (1999).

Strawson (1997, 1999) argues against the view that the self does not exist; he suggests that 'the sense of the self' is fundamental to human life. This appears to relate to the suggestion that the concept of 'self' is important in people's mental well-being (Charmaz, 1983, 1999). Strawson states that people have an experience of 'a self', and that this gives rise to the idea that the 'self' exists. Regardless of whether this represents truth or not, it is what appears to the case i.e., that we do have a self.

Strawson (1999) proposed a version of how the self might be understood (see fig 1), this model includes aspects of both the minimal self (fig 1, 1-4), a self which is the most basic and stripped down version of the self that can still be called a self and the narrative self (fig.1, 5-7). Strawson talks about SESMETS (Subjects of Experience that are Single Mental Things) as the minimal form of self experience, which is the experience of 'sensing the self'. Strawson proposes dispensing with (5)-(7), as these

can be absent in certain conditions such as: autism, schizophrenia, Cotard's Syndrome (where the person does not believe that they exist).

1. a *subject of experience*, a conscious feeler and thinker
2. a *thing*
3. a *mental* thing
4. a thing that is *single* at any given time, and during any unified or hiatus-free period of experience
5. a *persisting* thing, a thing that continues to exist across hiatuses in experience
6. an *agent*
7. as something that has a certain character or *personality.*

Figure 1.1 Strawson's model of how a self is represented

Both Metzinger and Strawson include in their theories of self elements of what is referred to as the 'narrative self'. This includes a sense of self which appears to have unity over time and is linked to personality. However, they concentrate mainly on the minimal aspects of the self, and view that version of self as having more validity. Dennett writes about the 'narrative self' (1991, as cited in Thornton, 2003) and views the self as an 'abstract object' created through people's use of language. Language has made it possible for people to have relative cohesion over time. It is through using this language to facilitate story-telling that we are able to tell stories about ourselves, and in doing so we are constructing our 'self', a narrative self. Dennett proposes that the narrative self acts as a centre of gravity around which numerous selves place themselves i.e., self as psychologist, self as daughter. The idea of the narrative self is important in the work of Lysaker and Lysaker, which will be explored later in the discussion.

Kircher and Leube (2003) present a model of consciousness and self-awareness. Within this model they evaluate the role of the sense of self. They propose the

existence of 'primary experiences', which are characterised by transparency, presence and 'myness'. These primary experiences reflect subjectivity i.e., how a glass of wine tastes to me does not reflect a truth about how the molecules actually taste. Rather it is my experience of those molecules interacting with taste buds in my mouth and then how that is represented in the brain that provides the sensation of taste. Thus there is no objective reality regarding primary experiences.

As well as these primary experiences Kircher and Leube (2003) posit the idea of primary self-experiences which contribute to the pervasive feeling of self. Primary self-experiences include: self-agency; self-coherence, the sense of being a physical whole with boundaries; self-affectivity, experiencing affect correlated with other experiences of self; self-history, a sense of existing over time. As with primary experiences, primary self-experiences give the 'sense of self' because they are transparent, and thus feel real. Kircher and Leube state that in the same way that primary experiences create the illusion that we are in direct contact with the external world, primary self-experience give us the illusion that the 'self' exists.

1.5 Concepts of the self and psychosis

1.5.1 Neuropsychology and the Cognitivists: 'minimal Self'

Evidence has indicated that the self plays a role in the experience of psychosis and schizophrenia (Parnas, 2000; Sass & Parnas, 2003). Much of people's experience of psychosis has been interpreted as reflecting abnormality in the sense of self. This review recognises that there are many other explanations of the processes involved in the development and maintenance of psychotic phenomena such as a dysfunction in the ability to integrate contextually stored information with current sensory input

and motor output (Hemsley, 2005). However, the purpose of this literature review is to examine the concept of self and its role, in schizophrenia/psychosis. Therefore, papers that present an understanding of the self in psychosis will be briefly reviewed.

Vogeley, Kurthen, Falkai and Maier (1999) suggest that the clinical features of schizophrenia can be viewed as a disturbance in the self-model, as proposed by Metzinger (2000c). They also propose that the prefrontal cortex can be shown to be of central importance in the experience of the different symptoms associated with the diagnosis of schizophrenia. Vogeley et al. relate the self-model to these symptoms. They state that a disturbance in the experience of ownership/agency correlates with experience of thought insertion/broadcasting and hallucinations, which are no longer experienced as self-induced perceptions. A disruption in 'perspectivalness' could result in feelings of depersonalization and derealization. Finally, a disruption in the experience of unity could result in the experience of depersonalization or in ego-dystonic symptoms.

Vogeley et al. (1999) present research from the field of neuropsychology and neurobiology to substantiate their proposal. They conclude from this evidence base that the pre-frontal cortex appears to be the most important "neuronal implementation of the self-model" (Vogeley et al., 1999, p355). Vogeley et al. suggest a unified concept: the self-model, behind the various sub-syndromes in schizophrenia. This opens debate into the validity of this kind of model of schizophrenia. There are many components implied in such a diagnosis and it is

unlikely that any single theory can properly account for a diagnosis that is inherently heterogeneous.

Villagran (2003) presents a review on the most recent approaches to the study of consciousness in schizophrenia. The research that is presented comes from the neurocognitive domains, including Frith (see below for more detail). This research differs in what is viewed to be the primary source of deficit i.e., whether there is a deficit in 'context', 'self-monitoring', or in 'cognitive dysmetria'. However, the research has in common the view that schizophrenia results from cognitive deficits and they do not appear to view any meaning in the resulting 'symptoms' of schizophrenia.

Frith, Rees, and Friston (1998) propose that psychosis is due to deficits in self-monitoring and this disrupts the sense of self. Frith has been particularly interested in experiences in which the patient feels that they no longer control their own actions, such as thought insertion and voice hearing, hence losing the sense of agency implied in Metzinger's model of self. Within these experiences the person retains a sense of ownership i.e., I am having these experiences, but the sense of agency is attributed to external forces i.e., but they don't belong to me. In order to understand how this disruption in the sense of self occurs, Frith et al. use the 'forward model in motor control' (Wolpert, Ghahramani and Jordan,1995 as cited in Frith, Rees, and Friston, 1998). The 'forward model' is said to distinguish between perceptions that originate within the self, like a thought, and those that belong outside of the self, hearing someone else talk. If this is disturbed then Frith et al.

propose that self-generated perception may appear as though externally generated, for example: voices, hallucinations, thought insertion, thought broadcasting. They created a testable hypothesis that the forward model is faulty in people experiencing what they termed 'passivity phenomenon'. They found support for their hypothesis, but in a critique of their own paper, they state that some of these results were found in clients regardless of their current experience of psychosis, therefore reducing the specificity of their findings. Kircher and Leube (2003) also found that impaired self-monitoring characterises people with a variety of clinical presentations and not just those where agency is thought to be affected.

Frith, Rees, and Friston (1998) appear to demonstrate that self-monitoring deficits are associated with people who have a diagnosis of schizophrenia. Their model attempts to identify an underlying deficit in self that is responsible for certain psychotic experiences. Despite their findings, it is possible that the self-monitoring deficit reflects only what is being observed, but that it does not necessarily imply that a deficit in self-monitoring is 'causing' the psychotic experiences.

Frith et al's model implies that schizophrenia is the result of an impairment in brain functioning. Sass (1998, 2003) argues against this view and proposes that schizophrenia results from a heightening in the awareness of 'the self' and the process of consciousness, which would normally be implicit. Sass and Parnas (2003) state that two aspects of the self are the main disturbances of consciousness affecting people's experience of psychosis and schizophrenia: diminished self-affection and hyperreflexivity. Sass (2003) defines diminished self-affection as "a decline in the

experienced sense of existing as a living subject of awareness" (p.155-156). Hyperreflexivity is defined as "a kind of exaggerated self-consciousness, a tendency for focal, objectifying attention to be directed toward processes and phenomena that would normally be "inhabited" or experienced as part of oneself (Sass, 2003, p.156)

Sass (2003) appears to be arguing that much of our awareness of self and consciousness is implicit, but through diminished self-affection and hyperreflexivity these are made explicit. Our thought processes are not generally brought into conscious awareness, in the same way that we are not usually consciously aware of the processes involved in moving the body. Most of that knowledge is generated proprioceptively; if we become too aware of how our body is moving this can impede our performance and the same can be true if we become too aware of our thought processes. As a result of a heightened awareness combined with a sense of alienation from one's own body, thoughts and emotions, Sass proposes that the person turns in on themselves and collapses, resulting in the presentation of schizophrenia. Sass also states that this process can lead to normal phenomena being interpreted as abnormal i.e., intrusive thoughts can be seen as thought insertion. O'Brien and Opie (2003) claim that this apparent collapse of the self does not occur because the self has become fragmented. Rather, it is because the system that gives the illusion of unity has broken down showing the self as it truly is i.e., a variety of 'selves' (also see Strawson, 1999).

So far there has been a review of papers that examine the concept of self in psychosis from a more biological/neuropsychological perspective. All of the above

models either cite a deficit model of schizophrenia (Frith et al., 1998; Vogeley et al., 1999) or they cite a disturbance in consciousness (Sass, 2003). These ways of understanding schizophrenia imply that it is internally generated i.e., that there is something wrong with the person's brain and this produces psychosis. However, schizophrenia is only one condition in which we see psychotic phenomena. Psychosis can also bee seen in drug use, sleep deprivation, and urine infection. Psychosis in these situations appears to have a more explicit 'cause', which appears to dissipate when the 'cause' is treated. It is hypothesised that sleep deprivation and certain drugs can affect the way the brain functions causing temporary disruptions in perception i.e., hallucinations. Can this also be applied where there is no obvious 'cause' for a psychotic reaction other then people's life experiences? Can this create changes in how people perceive the world? Spinelli (2001) cites research that indicated psychotherapy can be shown to alter brain chemistry (Parks, 2000 as cited in Spinelli, 2001) and demonstrated that environmental and experiential stimuli can alter the brain (Neugeboren, 1999 as cited in Spinelli, 2001)

In terms of life experience having a contributory role in psychosis, research by Kilcommons and Morrison (2005) showed that 94% of their sample had at least one traumatic event in their lives and 53% met the criteria for Post Traumatic Stress Disorder (PTSD). They found that severity of PTSD was linked to severity of psychotic experiences. Research into the link between trauma and psychosis shows that child abuse could be a causative factor for psychosis and has implications on how the brain develops (Read, van Os, Morrison and Ross, 2005). This research appears to show a link between peoples life experience in the development of the

brain and psychosis. Therefore, it may be appropriate to look at theories of the self and psychosis that take into account peoples lived experience and the impact that can have on the self.

Thomas, Bracken and Leudar (2004) suggest that the cognitivist models of schizophrenia try to account changes in peoples experience and behaviour in terms of faulty cognitive processing. The self is seen as a product of the mind, little attention being paid to external influences such as culture, historical factors and the individuals own lived experiences. However, the research indicated that there are cultural differences in peoples experience of psychosis. An international study of schizophrenia in sixteen countries found that outcomes in the Western world were poorer than those in developing countries (Sartorius, Gulbinat, Harrison, Laska and Siegel (1996). Castillo (2003) stated that in non-Western countries outcomes were ten times better than in the West. Castillo found that differences in cultural belief systems contribute to the differences in outcome. This makes the author question the purely biological basis of psychosis or schizophrenia. If it truly were a disease process, why would there be such extreme cultural differences? It is possible that within our culture there is a great deal of stigma attached to becoming 'mad' and that this may have an influence on how people go on to experience that psychosis. Link, Struening, Neese-Todd, Asmussen and Phelan (2001) carried out research into the consequences of stigma upon people with mental health problems. They found that the stigma associated with the development of mental health problems negatively impacts upon the person's self-esteem. Miller and Mason (2005) conducted research surrounding peoples feelings of shame and guilt in regards to

developing schizophrenia and schizoaffective disorders and of the importance of utilising therapeutic interventions aimed at reducing these feelings.

Thomas, Bracken and Leudar (2004) state that internalising peoples problems splits off peoples experience from the contexts in which they originate, and render this experience meaningless. They argue that cognitive science and neuroscience perpetuate Cartesian philosophy, in that the inner mind and outer world are kept separate. They question whether the self would exist without culture and context and believe that the question of meaning lies at the heart of a new framework for the psychiatric understanding of self.

1.5.2 Social constructivist and Narrative Approaches: 'Narrative Self'

Other researchers view the importance of meaning and context in peoples experience of self in psychosis or schizophrenia. Lysaker and Lysaker (2001, 2002 & 2005) have explored the breakdown of the 'sense of self' in psychosis in terms of the hypothesis that self is socially constructed through dialogue, both within the individual and between the individual and other individuals. They review the research regarding the view of the self as being 'dialogical' and hypothesize that a breakdown in the dialogue within the self and between self and others could results in disruptions in the 'sense of self'. This could compromise self-experience and result in the behaviours seen in people who experience psychotic phenomena. As a result of this disruption, a person's ability to own one's story or narrative stops evolving or growing and can be replaced by stories of illness, stigma and madness.

Lysaker and Lysaker (2002) present three cases with which to highlight how dialogue breaks down in people experiencing schizophrenia. They state that when dialogue breaks down, self-experience and personal narrative devolves into one of three forms: a 'barren and empty self-organization' (negative symptoms); 'internal cacophony' (thought-disorder, disorganisation); and 'self-constructions dominated by rigid, non-evolving monologues' (delusions). After reviewing the research, Lysaker and Lysaker suggest that disruptions in associative processes and affect dysregulation may profoundly interfere with internal and external dialogues and that this affects the sense of self (Philips, 2003). They also state that traumatic experiences can affect a person's narrative as reflected in the research into trauma and psychosis (Kilcommons & Morrison, 2005).

Lysaker and Lysaker (2005) have gradually expanded upon the use of the dialogical model of self in the course of their work. They now use the model to understand the whole gamut of symptoms associated with the diagnosis of schizophrenia. The author of this paper thinks there is a danger in trying to explain away the whole syndrome with one theory as it makes the assumption that a) 'schizophrenia' exists, and b) that it exists as a unitary disease process.

Trower and Chadwick (1995) present a model of how the self is constructed, coming from a more social constructionist view of self, where self is constructed in relation to others and social contexts. The self can be constructed in any number of ways; the role of the self as 'agent' is to choose how they want to present themselves to others in particular situations. Trower and Chadwick (1995) state that it is then necessary

for that self to be validated by others. They believe that attachment and autonomy are therefore necessary in the construction of self. The construction of self may fail if either of these is insufficient. Harrop and Trower (2001) apply this model to the development of psychosis in adolescent years. They believe that insufficient attachments can lead to poor constructions of the self; and that this can be exaggerated in people prone to psychosis.

Within a social constructionist view psychosis can be seen as one way of dealing with terrifying experiences in one's life, that do not have a language other than the one of hallucinations and delusions (Kilcommons & Morrison, 2005). Psychotic reactions are seen as attempts to make sense of one's experience. This idea is also widespread in psychoanalytic circles where the hallucination is classified as a 'road to the unconscious', i.e., what is not verbalizable is expressed through hallucinations (Prouty, 2004). Psychotic experiences are seen as having meaning and could be seen as the mind's attempt to express the traumatic experience. Prouty suggests that schizophrenia represents a severe split in the structure of self and states that psychotherapy of hallucinations could therefore lead to re-integration of self in schizophrenia.

1.6 How do these relate to clinical psychology?

From the literature review carried out, there appear to be a number of factors identified as to what constitutes a disruption in the sense of self. Most of the research points to there being a difficulty in the person maintaining a sense of agency and a sense of cohesion over time. The neuropsychological models of self in psychosis

appear to view these disruptions in the sense of self, and the appearance of psychotic experience, as part of a deficit or something internal to the person. If this is the case, then what are the implications for clinical psychology from this research? The author thinks that the models regarding how the self is constructed can be helpful to clinical psychology. Thinking about psychosis as involving problems in 'sense of agency' and 'unity over time' appears to be a helpful contrast to thinking about the positive or negative 'symptoms'. Also, the models of the 'self' show this concept of self to be the mind's fabrication and that a unitary self does not exist. This implies that self or personality, rather than being static, is a dynamic, ever-changing concept. This has the implication that the person can construct a different self or to build upon more helpful aspects of the self.

If the disruption of the self, as seen in people diagnosed as having schizophrenia is a result of a faulty brain, or faulty brain processes, then it is unclear how psychology can intervene to improve the sense of self. However, this does not reflect the evidence base for psychological therapies where reconstruction of the narrative self is key. The social constructivist and narrative approaches look at the role of the environment and culture upon the disruption of self and appearance of psychosis. Holma and Aaltonen (1997, 1998) carried out research into the use of Narrative Therapy with people experiencing acute psychosis. They state that this approach allows patients to re-find their sense of agency and reconstruct their narrative life story. They have shown through case examples, the effectiveness of a narrative approach in allowing people to recover from psychosis. Lysaker and Lysaker (2001, 2002, 2005) use a narrative approach in their approach with clients diagnosed with

'schizophrenia'. They state that through using this approach, the client's dialogue is revitalized and this enables a reconstruction of the client's narrative. Seikkula, Alakare, Aaltonen, Holma, Rasinkangas and Lehtinen (2003) utilised a narrative style of therapy in their Open Dialogue approach to working with people presenting with acute psychosis. Within the Open Dialogue approach the emphasis is on promoting dialogue with the aim of increasing the agency of the clients. Their research showed that the clients involved in this approach to therapy achieved better outcomes than clients receiving conventional treatments, namely neuroleptic medication. The improvements found were in terms of fewer hospital admissions and relapses and a return to a good level of functioning where more people were engaged in employment or studying.

Holma and Aaltonen (1998) show that the narrative approach allows the therapist to hear and try to understand the person with psychosis. They view that it is important that the person is viewed as an equal partner in the therapeutic conversations, and they do not let therapy be influenced by diagnostic stories. Lysaker and Lysaker (2002) suggest three requirements that may help awaken the internal dialogue: establishing a non-hierarchical relationship, encouraging the client to recall their story, and facilitating the client in the re-establishment of communication with varying aspects of themselves, without the therapists imposing their own biases.

The review of the literature found that life experience can have an affect of how the brain functions and can result in the experience of feeling separate from the 'sense of self'. If life experiences can create psychosis, can life experiences alter people's perceptions and help with the distress associated with psychotic experiences, or even

alleviate or reverse psychotic phenomena? The research on the effect of psychotherapy on the brain seems to support this idea.

1.7 Conclusions

The quest for 'scientific purity' in explaining the disturbance in the 'sense of self' as thought to be present in psychosis and 'schizophrenia' does not match the clinical picture. There are biases in how diagnosis is achieved, debates around the usefulness of the term 'schizophrenia', there are mass differences in clinical presentation across the spectrum, and occurrence of 'psychoses in the 'normal' population. Is it possible to apply scientific rigour to a concept that is not clearly defined? As a psychologist, and exploring the neuropsychological and neurobiological 'evidence', it paints a poor prognosis for people who go on to get the diagnosis of schizophrenia. However, as a psychologist, and in the experience of other psychologists, this does not paint the fairest picture of recovery in this area where it is known that over half of those meeting the criteria for schizophrenia go onto to make significant improvements over time and many go on to make a full recovery (Davidson and McGlashan, 1997).

This paper aimed to review the literature on the concept of the self in psychosis and schizophrenia. It is clear from the literature that there are many definitions of the self, and probably as many explanations for why the self becomes disrupted in schizophrenia. All of these theories are interesting in terms of trying to understand the self, but many of the theories appear to have limited practical use for clinical psychologists working in the area of psychosis. The research surrounding the

'narrative self' provides some hope that therapy can affect an improvement in certain aspects of the sense of self, such as improving agency and coherence over time. Clinical Psychologists should look at the possibility of taking the therapeutic focus away from the 'symptoms' of schizophrenia or psychosis and think about intervening in increasing agency and helping the client to regain coherence over time.

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Chapter II: Empirical Paper 1

The use of grounded theory to explore the experiences of clinical psychologists using a narrative approach with psychosis

Word count: 5805 (Excluding Abstracts, tables and figures, and References)

Abstract: 179 words

Being prepared for submission to: British Journal of Clinical psychology

2.1 Abstract

Objectives. Research into the use of narrative approaches by clinical psychologists is sparse. Identified research has shown that Narrative Therapy can be used, with good effect, with people who experience psychosis. The purpose of this study is to investigate the experiences clinicians have of using Narrative Therapy with adults who experience psychotic phenomena.

Method. Eight clinical psychologists working in various settings were interviewed following a semi-structured format, designed for the purpose of the study. The interviews were analysed using grounded theory and a model representing the experience of the clinicians is presented.

Results. Six main themes arose from the analysis of the data including: Society and Cultural Context, Power, Questioning Reductionism, Possible Ways of Understanding Psychosis, Characteristics of the Therapist's Approach: Opening Up, and Experiences of the Therapist. The main findings are explored with reference to the relevant research in the literature base.

Conclusion. The research appeared to be consistent with previous studies suggesting that creating a non-hierarchical, non-diagnostic climate in sessions is important in therapeutic interventions. Finally, limitations of the present study, clinical implications, and potential future research are discussed.

2.2 Introduction

Within the area of psychosis, there is a dominant view that psychosis represents a biological 'illness' in which first line treatment is medication. There has been a recent interest in the role of psychological therapies in psychosis in terms of Cognitive Behavioural Therapy for psychosis (Tarrier, Lewis, Haddock, et al., 2004). These treatments are viewed as being 'complementary' to the medical approach and appear to support some of the key components of this approach i.e., eradicating symptoms. However, there are psychological therapies that are not based on upon these principles. They are based upon constructivist theories which views there to be no objective reality, rather people construct meanings of the world in a dynamic interaction between the person and their social and cultural context. It is thought that there are multiple possible interpretations of realities and that this is reflected in the constant evolution of ideas throughout history (Neimeyer, 1993).

One such therapy approach is narrative therapy. There is limited literature on the use of narrative therapy with psychosis, therefore its benefits are not widely known. This paper is going to look at the experiences of clinicians who have used this approach in their work with clients who experience psychosis. Of interest are how therapists have used this approach, how they conceptualise psychosis, and what they have found helpful or unhelpful about using narrative therapy.

2.3 Background

2.3.1 What is Narrative Therapy?

Narrative therapy is founded upon the work of Michael White (1995). The theory behind the narrative approach suggests that human beings construct meaning in life

through stories and a narrative is the thread that joins the events. Narratives are created in a context and are influenced by the meaning given to them by society, the individual, and their families. Narrative therapy includes techniques such as externalising the problem, eliciting the alternative story and assisting people in recognising their personal agency (Carr, 1998). Externalising the problem is where problems are understood to be products of culture and history and not located within the individual. The process of building an alternative story, involves looking for unique occurrences in which the 'problem' has not occurred or has not invited the usual negative behaviours. Personal agency is apparently developed through enabling people to identify their own strengths and abilities to cope with their 'problems'.

2.3.2 Why use this approach in psychosis?

One of the aims of Narrative Therapy is to look at people's narratives surrounding their experiences, and to enable people to generate alternative stories to replace problem drenched stories (White, 1995). Research has shown that people who experience psychotic phenomena have a disrupted sense of self and lack narrative coherence (Holma and Aaltonen, 1997; Lysaker and Lysaker 2001, 2002). Holma and Aaltonen (1997) state that psychosis creates difficulties for individuals to search for a narrative, and that this causes a loss in the sense of personal agency. Lysaker and Lysaker (2002) investigated the narrative structure in psychosis and theorized possible explanations for the breakdown of narrative structure. They hypothesize that disruptions in the sense of self could compromise self-experience and result in the behaviours seen in people who experience psychotic phenomena. As a result of

this disruption, a person's ability to own one's story or narrative stops evolving or growing. In order to reawaken the internal dialogue they suggest: establishing a non-hierarchical relationship, encouraging the client to recall their story, and facilitating the client in the re-establishment of communication with varying aspects of themselves, without the therapists imposing their own biases.

Jorgenson (2004) looked at the active ingredients in individual psychotherapy and found that therapeutic conversations can contribute to the construction of a new narrative about the person's self and the world, one that supports the person's vital sense of meaning and coherence. Young and Ensing (1999) carried out research looking at the themes in recovery narratives. They found that the recovery process involved overcoming 'stuckness', discovering and fostering self-empowerment, and learning and self-redefinition. These processes appear to be consistent with the improvements noted when people are involved in the narrative approach.

2.3.3 Narrative Therapy for psychosis

Holma and Aaltonen (1997, 1998) carried out research into the use of Narrative Therapy with people experiencing acute psychosis. Within their approach with clients experiencing psychosis, they adopt a narrative style. This approach allows clients to re-find their sense of agency and reconstruct their narrative life story. They have shown through case examples, the effectiveness of this approach in allowing people to recover from psychosis. Holma and Aaltonen (1998) state that the narrative approach allows the therapist to hear and try to understand the person with psychosis. They view that it is important that the person is viewed as an equal partner in the therapeutic conversations, and to not let therapy be influenced by

diagnostic stories. Lysaker and Lysaker (2006) use a narrative approach in working with clients diagnosed with 'schizophrenia'. They state that through using this approach, client's dialogue is revitalized and this enables a reconstruction of the client's narrative. Dimaggio, Salvatore, Azzaria and Catania (2003) found that by utilising a narrative approach clients experience of emotional suffering diminished.

Much of the research into the effectiveness of narrative therapy employs single case methodologies, however Seikkula, Alakare, Aaltonen, Holma, Rasinkangas and Lehtinen (2003) carried out a research over a two year period. They utilised a narrative style of therapy in their Open Dialogue approach to working with people presenting with acute psychosis. Within this approach the emphasis is on promoting dialogue with the aim of increasing the agency of the clients. Their research showed that the clients involved in the Open Dialogue approach to therapy achieved better outcomes than clients receiving conventional treatments, namely neuroleptic medication. The improvements found were in terms of fewer hospital admissions and relapses and a return to a good level of functioning where more people were engaged in employment or studying.

O'connor, Davis, Meakes, Pickering and Schuman (2004) carried out an ethnographic study of therapists experience of using narrative therapy in a reflective team. Their analysis showed the therapy was effective in promoting improvements in the persons presenting problem for the following reasons: agency was increased, people were not pathologised, people were more able to deal with their problems,

and pathways for growth were opened. The researchers felt there needed to be more research on the use of narrative therapy by clinicians in different settings.

2.4 Rationale for this study

Investigation of the available research has shown that there is a lack of evidence, particularly in the United Kingdom, for the use of Narrative Therapy with psychosis. This study provides an insight into the clinicians view of a narrative style of therapy with clients presenting with psychosis. Grounded theory has been shown to be a suitable approach to study peoples experiences and to generate theory based on that experience (please refer to section 2.5.5.1 Grounded Theory for a fuller rationale). The researcher used this approach to learn how clinicians experience the therapeutic process and will identify the positives and negatives of that experience.

2.5 Method

2.5.1 Ethics

Ethical approval for this study was granted by the Warwickshire Ethics Committee (See Appendix 1).

2.5.2 Position of the Researcher

Several key experiences may feature within the researcher's interpretation of the data. Firstly, the researcher has been interested in the use of narrative therapy within psychosis for a number of years and therefore has a vested interest in adding to the evidence-base for that approach. This led her to consider what the helpful and unhelpful aspects of this approach in psychosis were and to introduce into the United

Kingdom research base the idea of using a narrative informed way of working with psychosis. She has endeavoured not to impose her beliefs about what might be helpful, when interpreting the data.

The researcher is also influenced by social constructionism, which informs her way of working with clients. She believes that society has a role to play in the creation of psychological difficulties and that in order to enable people to move on with their lives in a more helpful way, an understanding of that context is important. She has also been cautious not to presume that participants would also hold these as central values and ensured that the questions in the interview schedule were not leading the clinicians towards her biases. However, most of the clinicians that took part in this study were also influenced by ideas of social constructionalism, post-structuralism or community psychology, and this is therefore reflected in the findings.

2.5.3 Procedure and Participants

Clinicians were recruited through either an initial letter to all adult mental health services in North and South Warwickshire, Birmingham, and Shropshire or through e-mail contact to people known to have used narrative ideas within their work with people. The researcher made contact with the relevant clinicians to discuss the purpose of the research. They were given information about the research in the form of an information leaflet and discussion (see appendix 2). Eight clinicians agreed to participate in the research. They were then asked to sign a consent form (see appendix 3). They were informed of their right to withdraw from the research at any stage. All interviews were digitally recorded (audio) and participants were asked for their consent for this and were informed that the interviews would be erased after

they had been transcribed. They were told that the transcripts would be anonymous and that the researcher would transcribe the data. Please see Table 2.1 for a brief description of the participants.

Table 2.1. Descriptive Information about participants.

	Gender	Age	Occupation	Setting	Experience of using Narrative Ideas
1	M	45	Clinical Psychologist	Adult Mental Health Team	Using narrative ideas for 9 years and receives systemic and narrative supervision.
2	F	42	Clinical Psychologist	Medium Secure Unit	Using narrative ideas for 9 years
3	F	38	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 9 years
4	F	38	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 4 years. Has attended training.
5	F	35	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 5 years
6	M	41	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 4 years
7	F	40	Clinical Psychologist	Psychological Therapies Service	Using narrative ideas for 14 years
8	F	34	Clinical Psychologist	Acute Adult Inpatient Psychiatric Hospital	Attended a 5 day narrative conference and has been using narrative ideas for 6 ½ years.

2.5.4 Interviews

A semi-structured interview schedule was developed based upon the aims and research questions of this study (please see appendix 4). The eight interviews were conducted by the first author and lasted between 55 and 90 minutes.

2.5.5 Analysis of the data

2.5.5.1 Grounded Theory

The phrase "grounded theory" refers to theory that is developed inductively from a body of data (Glaser and Strauss, 1967). The original methodology proposed by Glaser and Strauss has been argued to be ambiguous and has therefore been interpreted in a number of ways (Willig, 2001). Strauss and Corbin (1998) outline how their method evolved as a natural progression of these ideas. Particularly, they suggest that the researcher undertakes more of an active role in shaping research than was originally proposed. Specifically, they suggest that the analyst should draw upon their own experience in order to identify relations within the data. This introduces an element of verification to grounded theory, creating an inductive-deductive approach rather than a purely inductive method (Rennie, 1998).

Several additional changes have been suggested that are in keeping with Strauss and Corbin's approach. Particularly, Charmaz (1995) introduces a social constructionist revision of grounded theory. This proposes that theory does not simply emerge from the data; rather, the theory is one particular reading but not the only truth. Charmaz's (1995) social constructionist revision appears compatible with Strauss and Corbin's (1990) acknowledgement that the researcher is actively involved in shaping theory.

This revision encourages the acceptance of multiple realities and encourages reflexivity; therefore it will be adopted in the current research.

Willig (2001) distinguishes between 'full' and 'abbreviated' versions of grounded theory. In the full version, theory is generated through a cyclical process of data collection and concept identification. Theory is deemed to be complete when concepts are fully developed to the point of 'saturation'. In the abbreviated version grounded theory is used as a method of data analysis for a pre-specified amount of data. This is appropriate in situations where there are time constraints or limited resources (Willig, 2001). As the current research is time-limited, this approach will be adopted.

2.5.5.2 Analytic Procedure

After the first interview, the data was analysed and coded (see appendix 5 for an excerpt of the transcript). Interviews were read line-by-line in order to develop sensitivity to the content of the data at the analytical level, to think at an abstract level (Strauss and Corbin, 1990). Analysis was carried out in three stages: open, axial and selective coding. The purpose of open coding (see appendix 6 for open codings) was to capture the substance of the data, and to break it up into smaller segments through identifying and joining substantive codes or concepts to form abstract categories (Strauss and Corbin, 1998). The next stage, axial coding, involved sorting the information and searching for patterns (see appendix 7). At this stage, the data was combined into a larger whole, by means of associations between categories and their subcategories. The researcher looked for cases that

demonstrated dimensional range or variation of a concept and the relationships among concepts (Strauss and Corbin, 1998). The final stage, selective coding, was the process where one category was chosen to be the core category, and related to all the other categories. The theory was then integrated and refined.

2.5.6 Issues of reliability and validity

Smith (2003) states that it is not helpful to judge qualitative research with the same reliability and validity constructs as used for quantitative research. Elliot, Fischer, & Rennie (1999) give guidelines for the publication of qualitative research in psychology and related fields. They list seven guidelines to help with judging the quality of qualitative research, which include: owning one's perspective, situating the sample, grounding in examples, and providing credibility checks.

The researcher has taken these into consideration. In terms of owning one's own perspective, a clear statement regarding the attitude, biases and theoretical orientation of the research is made explicit. In terms of situating the sample, demographic information is provided, within the bounds of confidentiality. It is also suggested researchers should provide examples of the data to illustrate the analytic procedures used in the study. It should be possible for the reader to conceptualise possible alternative meanings and understanding. The results section of this paper includes numerous extracts taken from the data, allowing the reader to see how the researcher constructed the various concepts and codes.

The guidelines suggest that authors may use many different techniques to ensure the credibility of their work. These include: independent audit and comparing two or more qualitative perspectives. Therefore any writing surrounding the research, such as any notes made, memos and codes, are open for external audit to carry out credibility checks. In order to verify the results of the research, additional persons were asked to check the results against the data and the themes and model were changed accordingly. Participants were also asked to give their opinion of the emerging theory and they thought the model was reflective of their experience.

2.6 Results

2.6.1 Emerging themes

The properties and dimensions of categories were expanded upon through the process of axial coding. This led to the construction of six overarching categories: Society and Cultural Context, Power, Questioning Reductionism, Possible Ways of Understanding Psychosis, Specific and Non-Specific factors in therapy, and Clinicians Philosophy. Selective coding was then undertaken in order to identify the core category.

This led to the selection of "clinician's philosophy" as the central concept amongst all categories (a detailed rationale is provided in section 2.6.2). The other categories were then arranged around this into a coherent model. Verbatim quotes for each theme have been included in Appendix 6. Hence, this section only includes a sample of verbatim quotes to illustrate each of the main categories. Table 2.2 shows all of the lower category themes, which comprise the higher category.

Table 2.2 Lower themes in relation to their corresponding higher theme.

Lower Order Category	Core Category
• Society's exertion of pressure through Roles and Standards • Cultural and Social Contexts • Differences in outcome • Possible reasons for differences • Family influences in psychosis • Social context of a person	**Society and Cultural Context**
• Client's Disempowerment • Powerful Systems • Clients: expert by experience	**Power**
• Questioning Medicalisation of distress • Medication: Limiting choices • Questioning Biological Influences • Questioning the eradication of perceived abnormalities • Alternatives explanations to medicalisation of distress • The effects of labelling • Questioning the utility of specific psychological/medical models • Questioning the idea of one way of making sense	**Questioning Reductionism**
• Disconnection from society • Making Sense • Psychosis as attempted solutions to relieve pressure/distress/uncertainty • Ways of understanding psychosis • Abuse/trauma and psychosis • Link between trauma and content of psychosis • Interpersonal Stresses	**Possible ways of understanding psychosis: opening up**
• Exploring meaning • Opening up choice: different perspectives • Externalisation • Use of story and alternative stories • Mapping Interpersonal relationships • Looking for people's resources • Client-centered and Client's agenda • Written communications • Transparency • Identity and therapy • Empowering the client/Agency • Helpful things • Standing alongside • Trust, Validation and Hope	**Specific and Non-Specific factors in therapy**
• Narrative approach as meta-theory: a philosophy • Therapist as a member of society • Therapist not fitting in with the dominant view of mental health • Therapist: Expert by experience • Powerful Therapist: redressing the balance • Therapist feeling supported	**Philosophy of the therapist**

2.6.2 Core Category

During axial coding many links were generated between categories. However, as categories became more systematically linked (by intentionally searching for connections between them), *"Clinician's philosophy"* was considered to have the greatest number of connections and thus was selected as the central concept. The "c*linician's philosophy*" appeared to be instrumental in how clinicians viewed the clients as existing within a social and cultural context, and inevitably led to their client-centred way of working. The "C*linician's philosophy"* also accounted for the multiple explanations found for psychosis in the "alternative explanations" category. A diagram of the model (figure 2.1) illustrates how the central concept was linked to all other categories.

2.6.3 Overview of the model

What appears to be core to the model, and encompassing of all other themes, is the clinician's philosophy. This, rather than narrative therapy per se, is the main guide to how they work with clients experiencing unusual beliefs or perceptions. Their philosophy is also informed by their experience of working with clients and looking at the contexts surrounding those experiences. Clinicians believe people exist within a social, historical and political and embodied context within which their 'selves' and their 'problems' are constructed. This drives the clinicians to be inherently client-centred in their approach to therapy. Due to this more critical way of viewing 'reality', they apply this criticism towards their views regarding mental health systems. They see clients as being disempowered by these powerful systems. Hence, the clinicians view it as important that the client is recognised as having expertise in themselves and their experience.

They are also questioning of the more dominant views surrounding how psychosis is constructed i.e., being seen as an illness or the result of a faulty brain. They view that psychosis is linked to peoples experiences, which is informed through their experience of working with clients, and therefore they see numerous different explanations for psychosis. Clinicians are also questioning of the dominant ways of 'treating' people who present with psychosis, therefore they are more likely to seek out other ways of working which reflects their underlying philosophy. This is possibly key as to why they choose to employ narrative ideas within their therapeutic style. Narrative therapy is based upon social constructivist ideals and is therefore complementary to the clinician's style. However, again this is governed by the idea that there is no one way of working with people and therefore the clinicians are eclectic in their style of working. The main guide to their style is what works best for the client and how the client views their difficulties.

2.6.4 Detailed Conceptualisation

Having provided an overview of the model a detailed account of the categories and subcategories generated will now be provided.

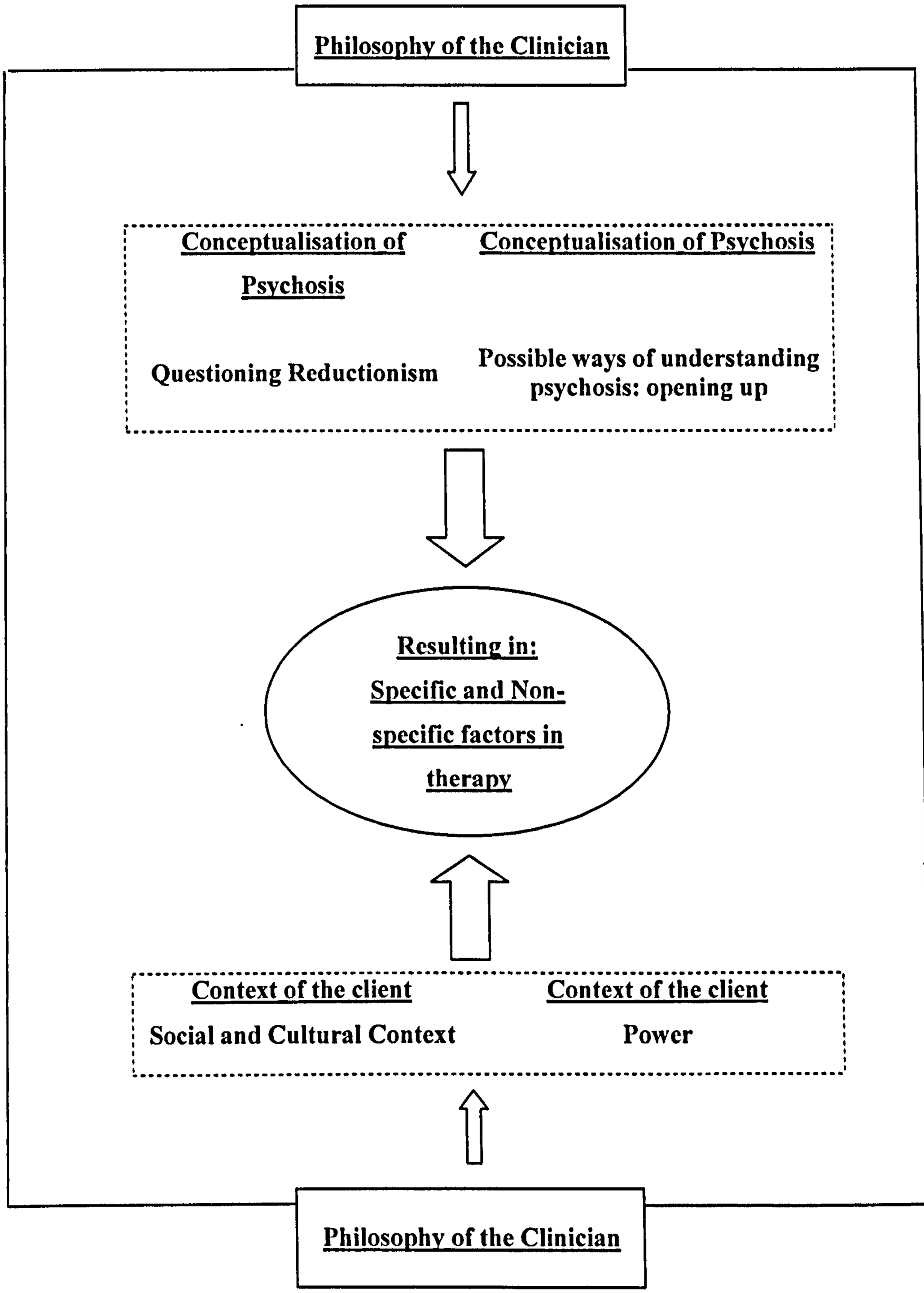

Figure 2.1 Diagram of the emerging model.

2.6.4.1 *Society and Cultural Context*

Analysis of the interviews indicates that psychosis is inextricably linked to the context in which people are living, both in the development of psychosis and in the outcome. Themes which arose from the analysis of the data as having more importance were **the social context of the person, the pressure of society's roles and standards** and **the cultural and social context.** Clinicians talked about how within our society, psychosis is highly pathologised and that this possibly has an impact on how people go on to experience psychosis (see quote 1, table 2.3). Clinicians went on to say that when someone then begins to have unusual experiences, because psychosis has been pathologised within this society, they experience secondary distress as a result of seeing themselves as 'abnormal' (see quote 2, table 2.3).

Table 2.3 Quotes illustrating the theme: Social and Cultural Context

Themes	Quotes
1.Cultural Context	*"[Psychosis] has been pathologised...I think it would be fine, if it maybe happened a bit more I think we would have had a different construction of things, if society understood it differently. Now because we live in a kind of medical society I think it is a natural progression within that context that we have this thing called psychosis, people kind of get diagnosed and get medicated." (8, p.3-4, line 32-6)*
2.Context of the Person	*"When people start to have unusual experiences the kind of wave of social influences kick in, people feel shame about that and feel it is difficult to talk about and be open to other people." (7, p.7-8, line 32-2)*
3.Outcomes	*"[In the developing world] I also think that family structures are different, this is a generalisation, but I think that social structures are based around extended families. So there are both more people around to look after vulnerable members of the family. The emphasis of that being what one does in the community [look after each other]. Whereas in the west the focus has become much more upon the individual." (6, p.2, line 14-21)*

Another theme to arise from the data was the difference in outcome between 'The West' and 'The Developing World'; people experiencing psychosis in developing countries have better prognoses than in 'The West'(see quote 3, table 2.3). Research

lends support to this idea and this will be explored later in the discussion. The clinicians felt there were various reasons to account for the differences in outcome. The elements that seemed to be important in people having a better prognosis were family and community support.

2.6.4.2 *Power*

The clinicians talked about the role of power in relation to peoples experiences of psychosis. There seems to be a feeling that disempowerment plays a role in someone developing psychosis (see quote 1, table 2.4). When they then enter mental health services or are labelled as having psychosis, they experience a further disempowerment as they are not listened to and their experiences are not believed (see quote 2, table 2.4).

Table 2.4 Quotes illustrating the theme: Power

Themes	Quotes
1.Disempowerment	*"I think it is probably about disempowerment, feeling very separate from prevailing social norms. Being caught up under societal discourse." (1, page 1, line 4-6)*
2. Powerful Systems	*"Those power relationships between mental health professionals, like doctors and clients are atrocious. If people are saying 'I don't want to take it, it's not helpful' we should be looking at that." (2, p.22-23, line 34-2)*
3. Client as Expert	*"Clients/service-user brings a whole load of things too, their own expertise as well and their own experience of themselves, so I think it is important to collaborate." (7, p.13, line 4-6)*

Although the role of the therapist can be one associated with power, the clinicians talked about trying to redress this. Important to the clinicians was to respect the client's expertise and what they bring into therapy (see quote 3, table 2.4). The clinicians recognised that they did not have the expertise in what it was like to have these unusual experiences or to have lived their client's lives. This links to how the

clinicians interact with the clients in therapy, in terms of empowering the client and adopting a client-centred approach.

2.6.4.3 *Questioning Reductionism*

The theme 'questioning reductionism' mostly involved a questioning of the medical model and its drive to reduce complex psycho-social problems to an 'illness'. The clinicians questioned people being reduced to a label i.e., being seen as 'psychotic' or 'schizophrenic' (see quote 1, table 2.5). The clinicians thought that this approach deprives the person of any meaning or context to their difficulties, other than a medical view. The results suggest that this has implications upon how the person comes to view themselves.

Table 2.5 Quotes illustrating the theme: *Questioning Reductionism*

Themes	Quotes
1.Medicalisation And Labelling	*"If you take psychosis as the medical model and you say to someone 'your psychosis is part of a medical illness', then you are defining them in a certain way and you are defining them according to a deficit, to a illness, according to something negative really." (4, p.5, line 4-8)*
2. Eradication	*"...I think they are working on an eradication model, which is contradicting the you can live along side it, because it is giving that message that we need to eradicate and medication is being given quite aggressively." (8, p.11, line 22-26)*
3. Continuum	*"I think I have increasingly come to understand that what we call psychotic experiences are sort of variations of what can be seen as normal human experience ways of behaving and ways of thinking. So in that way I see it as an ordinary part of a way of functioning." (6, p.4, line 26-31)*
4. Models	*"I think that it is very individual though, I don't think you can prescribe one therapy that will suit everybody. It's a bit like the CBT for psychosis at the moment; it has become the therapy for psychosis, whereas it is not going to be right for everybody." (6, p.13-14, line 30-2)*

The medicalisation of distress contradicts the clinicians view that peoples experience is the result of a dynamic interaction between that person and their social context. The clinicians also talked about how it is dominant in the medical model that 'psychotic symptoms' should be eradicated (see quote 2, table 2.5). They imply that this limits peoples choice in how they want to view their experiences.

The clinicians offered alternative views to the medicalisation of distress. They seemed to say that psychosis can be conceptualised as being on a continuum of 'normal experience' (see quote 3, table 2.5). Connected to this was the idea that there was a fine line between what is viewed as psychotic and what is not. This appears to link to the theme of there being a social context surrounding psychosis, therefore diagnosis is not a 'black and white' issue, but is open to interpretation.

There seems to be an opinion amongst the clinicians that the use of any model in a prescriptive way, is not a good thing (see quote 4, table 2.5). This links to the clinicians' philosophy to therapy in that they do not reject any explanation or model. They suggest that used in the right way, it does not matter what model is used. If any model is used in a prescriptive way, including the narrative model, then this is going against what works best for the client, which appears to be fundamental to their approach.

2.6.4.4 *Possible ways of understanding psychosis: opening up*

Analysis of the interviews showed that the clinician had a variety of ways of understanding psychosis. These alternatives came out of the clinicians' experience of working with people with psychosis. This experience led them to view psychosis as having meaning in regards to that person's life experience. The themes that were most strongly supported were those regarding abuse or trauma (see quote 1, table 2.6). Clinicians also talked about psychosis as being an attempted solution to try and cope with feelings of uncertainty, distress and pressure (see quote 2, table 2.6).

Table 2.6 Quotes illustrating the theme: Ways of understanding psychosis

Themes	Quotes
1. Reasons for psychosis	*"I think in general people have those experiences because things bad things have happened to them. Usually sexual abuse or other forms of victimisation and difficult family situations...all those things we hear about kind of account for a lot of those reasons that people have those experiences." (7, p.1, line 16-22)*
2. Attempted Solutions	*"I would say that they [psychosis] serve a purpose, and that depends on the person. Whether it is that something is unresolved such as the grief thing. Or that whatever has happened to them has been too dreadful for them, for them not too split it off." (3, p.5, line 1-5)*
3.Disconnection	*"Whatever it is there has been a disconnection from other people, a loss of social support and relationships. That has gone on for quite a long time before somebody has come through these doors to say that they don't think things are right." (6, p.3, line 20-24)*

Another way of understanding psychosis that has arisen from the data is the suggestion that when people are experiencing psychosis there appears to be a disconnection from society. This is then followed by further disconnection because of their experience, and finally if they are in contact with mental health services, or

hospitalised, this further separates people from society (see quote 3, table 2.6). This links to the research into recovery and on adolescents where re-establishing connections is key (see the discussion for more on this link).

2.6.4.5 *Specific and Non-Specific factors in therapy*

From the analysis of the research, it appears that the clinicians' style in therapy relates to their philosophy regarding the world, i.e., social-constructionist or post-structuralist ideas around multiple realities and the influence of society upon the person's construction of themselves. What appears central to the therapy is the notion of being client-centred. This enables the clinician to use techniques in ways that are respectful to the client's understanding. They remain critical of their approach, which is guided by their philosophy. A fuller exploration of this theme has been presented in empirical paper two; therefore, for the purpose of this paper, the less supported themes will not be represented here.

One of the things that the clinicians talked about doing with clients was exploring the meaning of the psychosis (see quote 1, table 2.7). This appears to be in opposition to the eradication model, as the clinicians are not focusing on purging the experiences, but upon understanding them in their context. This seems to be associated with the theme of client's gaining a richer understanding of themselves as a result of therapy and also to developing a richer story.

Table 2.7 Quotes illustrating the theme: Specific and Non-Specific factors in therapy.

Themes	Quotes
1. Meaning	*"I think it is more important to have a meaning...you both construct meaning together, any meaning that is useful to the client, rather than a true meaning as you will never really know what the true meaning is." (2, p.7, line 21-26)*
2.Externalisation	*"People who find [externalisation] useful have said to me that it is about a control thing or it enables them to feel less guilty or less blamed. They have a relationship with the problem and that in any relationship your position can move around and it doesn't have to push you around so much. You can create some resistance to it and allow it in if you want to" (1, p.5, line 7-14)*
3a. Story	*"It is important to have this process of reflection going on at the same time as they are telling you their story...questions like 'how did you feel about that', 'what sense did you make of that'...it's constant questioning and reflecting, not just tell me about your life." (2, p.10, line 2-9)*
3b. Story and Change	*"I think somebody's stories... and how they tell their story and how they can have conversations about their story, is the main place where change can happen. Whether it is through having eureka moments...like 'ah, that links to that and that links to that'. Or, whether it is a very slow process of reaching an understanding ...and getting someone to a place of acceptance." (3, p.16, line 10-18)*
4. Identity	*"For the client they have a greater sense of contentment in who they are and a greater understanding of who they are and how they got there." (2, p.29, line 7-10)*

One of the key things that the clinicians used as part of their therapy was externalisation, positioning the 'problem' outside of the person (see quote 2, table 2.7). This contrasts with the individualisation of distress found within the medical model, where problems are located within the person. Through externalisation, clinicians were talking about clients choices being opened up again as they can have a relationship with their experiences.

Enabling a person to narrate their own story was another of the key factors in therapeutic style (see quote 3a, table 2.7). The clinicians talk about this in relation to helping clients to build up a narrative through using reflection and tentative hypothesising. The 'use of the client's story' links the understanding that there is a social and historical context to the person. Through this, clinicians can help the person to explore the meaning of their experiences. According to the clinicians, this is a place where change can occur (see quote 3b, table 2.7). It seems that a richer understanding is almost the result of this approach to therapy, the client learns more about who they are (see quote 4, table 2.7).

2.6.4.6 *Clinician's Philosophy*

It has become clear throughout the themes that the philosophy of the clinician is a key component in how they are in therapy and guides the importance of the social context and the more critical view of specific approaches, including their own (see quote 1, table 2.8). The analysis of this research suggests that through having this philosophy, the clinicians are more client-centred in therapy and are critical of their own practice and suggestions in therapy. It is possible that through adopting this approach the client is able to build a good relationship with the therapist which could be the catalyst for change.

Table 2.8 Quotes illustrating the theme: Clinician's Philosophy

Themes	Quotes
1. Philosophy	*"I think in some ways, if you take a more social constructionist view, it offers some way of trying to critique your own position as a therapist, 'expert'. It provides a framework for asking yourself questions like 'why are you choosing one alternative story rather than another?', 'why this explanation and not another?' the consequences of that really. It kind of encourages a more critical view over your own actions." (6, p.10, line 16-24)*
2. Power in Therapy	*"As ideas come into my head 'I'm thinking this and that' 'what are your thoughts on that', inviting collaboration, I guess deconstructing the expert position really and not sitting there saying I am the expert on psychosis. I have ideas and experience, but they have ideas and experiences so, collaborating really and throwing my ideas and what I am hearing back to them for comments." (8, p.9, line 1-8)*
2. Expert by Expertise	*"I think that we do have expertise in all these kinds of theories that we have about things and knowledge that we have. We have also talked to a lot of people who have gone through very similar experiences, so that gives you a certain amount of expertise, that having some kind of experience." (7, p.12, line 9-14)*
4. Therapist not fitting in.	*"The best teams I have worked in we have all been looking at things in the same way. At other times, I have thought that they also felt that I was deluded, that we were almost caught up in this 'folie a deux'." (2, p.23, line 26-29)*

Clinician's also talked about the therapist being a powerful person in the relationship (see quote 2, table 2.8). The clinicians acknowledge that this power imbalance exists and employ their client centred ideas to redress this balance and to empower the clients. They do view that they have some expertise in relation to certain theories and techniques they have knowledge of and also in terms of having spoken to lots of people experiencing similar difficulties. The clinicians reflected the idea that they were 'experts by experience' in a similar way to the clients (see quote 3, table 2.8).

There was a view amongst the clinicians that because their philosophy is so opposite to the dominant view in most mental health services, it can cause some difficulties

(see quote 4, table 2.8). However because of their philosophy, they extend the same values to their colleagues and are transparent and respectful of other peoples models. In order to cope with possibly being in a hostile environment, the clinicians have found it helpful to have the support of people or communities who share similar ideas to them.

2.7 Discussion

The core theme arsing from this research was the 'clinician's philosophy' being key to their approach to therapy; more so than the narrative model. Clinicians were guided by their philosophy in terms of the techniques they used in therapy, how they interacted with the clients and with their colleagues. So although they used narrative techniques, they were not guided by a 'Narrative Model'. This relates to Burnham's (1992) Approach-Method-Technique (AMT) model. Burnham (1992) proposes that by using the AMT model, it becomes possible to employ a wide range of methods and techniques while remaining consistent with the practitioner's theoretical orientation. The quote below show's how Burnham's model is reflective of the model I have proposed as representing the clinicians approach to therapy:

> *"This level of approach is more than a collection of theories, concepts and working ideas. It embodies a practitioner's disposition towards their work with clients, colleagues and institutions." (Burnham, 1992, p.3)*

There appears to be a feeling amongst the clinicians that 'narrative therapy' is represented in the literature as an all encompassing way of working, rather than just one possibility. Neimeyer (1993) suggests that as with all ways of thinking, constructivist ideas are situated within a social context and a certain point in time.

'Behaviourism' and 'Cognitivism' have both been hailed as the 'way of working' in the context of the time they were introduced. But ideas change, and thinking moves on, the same can be true of how constructivist therapies are regarded. This needs to be taken into account when espousing the benefits of one approach over another. The author feels that this questioning is reflected within the transcripts of the clinicians.

Another major theme arising from the research is the role of culture and context in how psychosis is understood. Clinicians thought that psychosis is viewed within this society as being part of an illness, something that is a deficit and needs to be eradicated. This is influential in how people go on to experience psychosis. Roe and Davidson (1995) show the damaging effects upon a person's agency through being pathologised and argue that recovery is linked to regaining that agency and creating a coherent life story. Clinicians thought that if we existed in a culture where hearing voices can be conceptualised as being part of a spiritual experience, then it appears less likely that people will have a distressing reaction to those experiences. This suggestion, of there being a difference in outcome, depending on cultural beliefs, appears to be supported by the research. An international study of schizophrenia in sixteen countries found that outcomes in the Western world were poorer than those in developing countries (Sartorius, Gulbinat, Harrison, Laska and Siegel (1996). Castillo (2003) cited that in non-Western countries outcomes were ten times better than in the West. Castillo found that differences in cultural belief systems contribute to the differences in outcome. Kirmayer (2005) also states that the prominence given

to a particular model in understanding 'symptoms' and 'illness' are determined by the social context in which it occurs.

'Alternative explanations' for people's experience of psychosis arose as a major research theme. There is a significant amount of corroborating information in the literature, part of which will be presented here. In terms of trauma having a contributory role in psychosis, research by Kilcommons and Morrison (2005) showed that 94% of their sample had at least one traumatic event in their lives and 53% met the criteria for PTSD. They found that severity of PTSD was linked to severity of psychotic experiences. Research into the link between trauma and psychosis shows that child abuse could be a causative factor for psychosis and has implications on how the brain develops (Read, van Os, Morrison and Ross, 2005). In considering the clinicians view that disconnection plays a part in psychosis, Harrop and Trower (2001) cite reconnection with peers and encouraging romantic relationships as being key in promoting recovery from psychosis in adolescents.

2.8 Conclusion

The proposed 'model' represents the clinicians' way of working with people experiencing psychosis. It takes into account the person's way of understanding their experiences. This is not centred on the psychosis; psychosis is only relevant in how it relates to the client's experiences. The clinicians view that people who present to services with psychosis, have predominantly experienced lives that are characterised by abuse, trauma or interpersonal stresses. Clinicians validate the experience clients have and view the psychosis as being an effect of that experience and not the cause

of their distress. Therefore, their way of working reflects this and concentrates on enabling people to make sense of their life experiences, of which psychosis is merely one element.

Narrative therapy is held up as being founded upon constructivist principles. However, some of the main authors regarding the use of narrative therapy in psychosis still work within an illness framework (Holma and Aaltonen, 1997, 1998; Lysaker and Lysaker, 2006). They appear to view 'schizophrenia' as an illness that 'afflicts' people, and talk of patients, treatments and symptoms. Narrative theory is one that is based upon the importance of the language we use in permeating the dominant views of society. The word 'patient' immediately brings to mind 'the person to whom things are done to', rather than viewing people as equal collaborators in the therapeutic process. This does not represent a non-diagnostic approach if the basic assumption of those authors is that people are ill.

2.9 Limitations

There were a number of limitations to this study. The first pertains to the relatively small sample size; unfortunately it appears that the use of a narrative approach with people experiencing psychosis is very limited. The author covered a fairly wide area of the country in order to interview this selection of clinicians. Therefore it can be said that it is possible that this small sample size is representative of the clinicians using this approach within the United Kingdom.

Another criticism of the approach could be that none of the therapists would describe themselves as 'narrative therapists' per se. However this again appears to be representative of how this approach is adapted in order to work with this client

group. The author contacted a number of therapists who specialise in the narrative approach. However, they reported they did not receive referrals for people experiencing psychosis. This is possibly reflective of the wider problem of people with psychosis not being referred for humanistic psychotherapies.

2.10 Future research and clinical implications

It is hoped that this research can provide a good starting point in considering how to advance the use of a narrative style of therapy with people experiencing psychosis. Further research needs to be carried out addressing the client's views of the therapy process to highlight how they perceive the processes in therapy. It would be helpful if a measure could be designed to detect change in therapy when adopting this approach which is not based upon more dominant theories of what constitutes change in terms of reduced reporting of psychotic experiences.

Analysis of the research indicates that it is not of vital importance what techniques or models used in therapy. If therapists can absorb into their practice some of the ideas explored in this research, i.e., being client-centred and creating a non-hierarchical relationship, then it is possible that improvement can be obtained in the effectiveness of therapy with this client group. However, this is given with the obvious limitation that therapy is only one aspect of the influences upon the client and therefore any changes in therapy will be influenced by outside forces.

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Chapter III: Empirical Paper 2

The use of Grounded Theory to explore agents of change in a narrative style of therapy with adults experiencing psychosis

Word count: 2804 (Excluding Abstract, Tables and figures, and References)

Abstract: 120

Prepared for submission to: British Journal of Clinical Psychology

3.1 Abstract

Objectives. The purpose of this study is to investigate clinician's experiences of using a narrative style of therapy with adults who experience psychotic phenomena in order to identify those aspects that are important in facilitating change.

Method. Eight clinicians were interviewed for this research using a semi-structured interview. The interviews were analysed using a grounded theory approach.

Results. The results identified four major themes, which were: the style of the therapist: client-centred, agents of change, balance of power and blocks to progress.

Conclusion. The research appeared to be consistent with previous studies suggesting that creating a non-hierarchical, client-centred climate in sessions is important in therapeutic interventions. Finally, limitations of the present study, clinical implications and potential future research are discussed.

3.2 Introduction

Carr (1998) presents a précis of the key elements of narrative therapy. These include: a collaborative approach, externalising the problem, looking for unique occurrences, thickening the new story, making links between past, present and future and outsider witness. Research has shown that narrative therapy can be helpful for people experiencing psychosis, one of the reasons being that they have a disrupted sense of self and lack narrative coherence (Lysaker and Lysaker 2001, 2002). Holma and Aaltonen (1997) state that psychosis creates difficulties for individuals to search for a narrative, and that this causes a loss in the sense of personal agency.

Lysaker and Lysaker (2002) hypothesize that a person's ability to own one's story or narrative stops evolving or growing and can be replaced by stories of illness, stigma and madness. They suggest three requirements that may help awaken the internal dialogue: 1. the establishment of a non-hierarchical relationship; 2. the willingness and encouragement to help the client recall their story and 3. facilitating the client in the re-establishment of communication with varying aspects of themselves, without the therapists imposing their own biases on the reconstruction of the client's story.

Holma and Aaltonen (1997, 1998) carried out research into the use of Narrative Therapy in people experiencing acute psychosis. They argue that a narrative approach allows patients to re-find their sense of agency and reconstruct their narrative life story. They have shown through case examples, the effectiveness of a narrative approach in allowing people to recover from psychosis. Holma and Aaltonen (1998) state that the narrative approach allows the therapist to hear and try to understand the person with psychosis. They view that it is important that the

person is viewed as an equal partner in the therapeutic conversations, and do not let therapy be influenced by diagnostic stories.

In summary, the research pertaining to the use of narrative therapy for psychosis is promising. However, there is a lack of research being carried out in this area, especially in regards to the particular factors that could lead to a change in a person's narrative. Therefore the current research aims to add to the current knowledge base.

3.3 Method

3.3.1 Qualitative Methods – Grounded Theory

Grounded theory has been shown to be a suitable approach to study the experiences of service users and to generate theory based on their experiences. The researcher utilised this approach to learn how participants experience the therapeutic process and identify the positives and negatives of that experience. As the method utilised for the current research is the same as in the empirical paper contained in chapter one, please refer to method section of that paper for a more in depth discussion.

3.3.2 Ethics

Ethical approval for this study was granted by the Warwickshire Multi-Regional Ethics Committee. (See Appendix 1)

3.3.3 Procedure and Participants

Clinicians were recruited via a letter or through email contact. They were given information about the research in the form of an information leaflet and consent

form (see appendix 2 and 3). Eight clinicians agreed to participate in the research. Please see Table 1. for a brief description of the participants.

Table 1. Descriptive Information about participants.

	Gender	Age	Occupation	Setting	Experience of using Narrative Ideas
1	M	45	Clinical Psychologist	Adult Mental Health Team	Using narrative ideas for 9 years and receives systemic and narrative supervision.
2	F	42	Clinical Psychologist	Medium Secure Unit	Using narrative ideas for 9 years
3	F	38	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 9 years
4	F	34	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 4 years. Has attended training.
5	F	35	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 5 years
6	M	41	Clinical Psychologist	Community Mental Health Team	Using narrative ideas for 4 years
7	F	40	Clinical Psychologist	Psychological Therapies Service	Using narrative ideas for 14 years
8	F	34	Clinical Psychologist	Acute Adult Inpatient Psychiatric Hospital	Attended a 5 day narrative conference and has been using narrative ideas for 6 ½ years.

3.3.4 Interviews

A semi-structured interview schedule was developed based upon the aims and research questions of this study (please see appendix 4). The interviews were conducted by the first author and lasted between 55 and 90 minutes. In this article the participants are referred to as C1-C8.

3.3.5 Issues of reliability and validity

A number of techniques were adopted to ensure the quality of this research according to published guidelines (Elliot, Fischer, & Rennie, 1999). These were: 1. Any writing surrounding the research, such as: any notes made, memo's and codes, are open for external audit to carry out credibility checks and memo's and codes are available in appendix 8 and 9; 2. Additional people were asked to check the results against the data and the model and themes were changed accordingly; 3. The researcher was involved in a qualitative research group; 4. Selected participants were asked to give their opinion of the emerging theory and these opinions were incorporated into the research. Feedback from the participants indicated that they felt the themes were, on the whole, reflective of their experience.

3.3.6 Position of the Researcher

Firstly, the researcher has been interested in the use of narrative therapy within psychosis for a number of years and therefore has a vested interest in adding to the evidence-base for that approach. She has endeavoured not to impose her own beliefs about what might be helpful, when interpreting the data. The researcher is also influenced by ideas within social constructionism, which informs her way of working with clients. She has also been cautious not to assume that participants

would also hold these as central values and ensured that the questions in the interview schedule were not leading the clinicians towards her biases.

3.4 Results

3.4.1 Emerging themes

The properties and dimensions of categories were expanded upon through the process of axial coding. This led to the construction of four overarching categories: Style in therapy: Client-centred, facilitators of change, balancing power in therapy, and blocks to therapy. Selective coding was then undertaken in order to identify the core category of Style in therapy: Client centred.

3.4.2 A model of the change process in a narrative style of therapy

Analysis of the data revealed the idea of a model of change in therapy, which was not based upon a simplistic cause and effect model. The occurrence of change happens within a therapeutic and societal context. The style of the therapist appears to create an environment in which the client and their experiences are at the centre. The clinician is interested in learning about the client and adopting a style whereby that client feels validated and listened to. Connected to this is addressing the balance of power in the therapeutic alliance, which is aimed at empowering the client. However as previously mentioned the therapeutic relationship takes place within a social context and this context has a dynamic effect on outcome in therapy.

3.4.3 Common Themes

3.4.3.1 ***Style in therapy: Client-Centred*** (For quotes about this theme refer to table 3.2)

From the analysis of the research one elements that appears to facilitate a more helpful narrative for the client was the clinician exploring the meaning of their experiences. This was talked about in terms of helping the client to make sense of their past and the here and now. Clinicians expressed the view that through talking with the client about their context, a better understanding of their experiences can be achieved. This is something most of the clinicians found were an important part of their work with clients. Another way the clinicians were talking about working with clients was by opening up choice and seeing things from different perspectives. All of the clinicians talked about offering choice and different perspectives to their clients. They talked about how much of the time client's choices have been limited and that in therapy this can be opened up for them.

The notion of being client centred is central to the therapy that is carried out. Even though people use narrative ideas, it is always with the proviso of what is best for the client. This client-centeredness is also reflected in the setting of the agenda for sessions. Research analysis showed that clinicians felt what was important was the client's agenda and not the therapist's. The story is built up around what the client chooses to talk about, and does not follow a structured assessment format, as tends to be used in other approaches e.g. cognitive-behavioural therapy. Clinicians applied their client-centred style of therapy to their written communication as well. Clinicians talked about writing reports and therapy notes in an open and transparent

way: Three clinicians talked about using therapeutic letters, which they thought were helpful in terms of the client being able to remember the sessions and to be able to state positive things about the client.

Also linked to the style of the therapist are several aspects, which appear to relate to the building up of a therapeutic alliance. These were being: transparent and open in the way they chose to work with both clients and other professionals; standing alongside the client as opposed to imposing their ideas and ways of working upon the client; and the validation of the client's life experiences as well as their experience of psychosis.

Table 3.2 Quotes regarding the theme: Style of therapy: Client-centered

Lower Order Category	Number of quotes	Number of clinicians	Quotes
Exploring meaning:	18	7	*"With a lot of the people I see that is what the work has been about, trying to understand how that has come about and why they have those kinds of difficulties. Because I think one of the things that people do struggle with is they don't really have a story for that." (7, p.4, line 1-5)*
Opening up choice different perspectives:	13	7	*"To help them to understand the meanings that they have made, and to help the person to look at this from different angles, alternative ways that thing could be made sense of, in way that was helpful." (2, p.16, line 22-25)*
Written communications	10	4	*"Writing my notes in that way and then even when I am writing notes, being quite transparent with that process, so they can have access to my note, they can read them if that makes sense to them." (8, p.9, line 15-18)* *"I quite often write letters, so the idea of letter writing and of putting down on paper positive things about the client and things which stress how much they have done to get this far..." (4, p.9, line 23-29)*
Client-centred	17	6	*"I hope I am very client-centred, it's not doing this in session one, this in session two. It's a constantly evolving process in relation to what the clients needs are." (2, p.12, line 32-35)*
Client's agenda	15	8	*"Initially I am interested in listening to what people have got to say. I don't go in there with a real set agenda of 'I have to know a certain set of information by session one'." (4, p.8, line 4-7)*
Transparency	13	4	*"I think you have to be fairly transparent to the client and say, well that is their view and I don't actually share it, or there are different view about this, your ex-professional thinks this and I think this - just being transparent is helpful." (7, p.14, line 23-27)*
Standing alongside	9	4	*"I hope that in therapy, someone might think of me as standing alongside them...being on their side to fight [the psychosis] through the conversations you have with people." (1, p.8, line 6-9)*
Validation	14	4	*"I think [listening to people's views on medication] is an important part of validation for people; people have experience of psychosis and have some form of abuse history or history of neglect or certainly a history where their emotions haven't been validated." (4, p.12, line 24-28)*

3.4.3.2 ***Agents of change*** (For quotes illustrating this theme refer to table 3.3)

One of the more recognizable narrative techniques that clinicians used was externalisation. Based on the analysis, clinicians felt that this was helpful in allowing people to have a different relationship with their experience of psychosis. Clinicians talked about externalisation in terms of the client regaining power and beginning to challenge their experiences. This links with what the clinicians were saying about opening up choices for the client.

Another technique that the clinicians used was the idea of people's stories. Firstly in gathering a story that is client-centred and about how they have understood their context. Then in terms of building up, in collaboration with the client, an alternative story to the more dominant problem saturated stories. Clinicians talked about this technique as being an important place where change can happen and that it can be liberating for people to consider alternative ways of viewing their lives. Linked to trying to build up the person's story is mapping interpersonal relationships. Half of the clinicians were interested in using genograms and time lines to build up a story regarding client's interpersonal history.

The clinicians talked about helpful things; components of therapy that they found helpful in producing change, and also what the clients have found helpful. These related to offering different perspectives, doing things outside of therapy and the flexibility offered by the approach. Inspiring hope in clients was also seen as a helpful aspect of therapy that appears to facilitate change. Another important

Table 3.3 Quotes regarding the theme: Agents of change

Lower Order Category	Number of quotes	Number of clinicians	Quotes
Externalisation	26	7	*"People who find [externalisation] useful have said to me that it is about a control thing or it enables them to feel less guilty or less blamed. They have a relationship with the problem and that in any relationship your position can move around and it doesn't have to push you around so much. You can create some resistance to it and allow it in if you want to" (1, p.5, line7-14)* *"I also liked the idea in narrative therapy of externalising problems as a way of somebody enhancing their sense of agency and control over problems and again that fitted with me working with people with psychosis because they is a conflation of identity with psychosis, socially and in mental health services." (6, p.9, line 27-33)*
Use of story	18	7	*"I suppose what I have broadly found helpful about narrative therapy is the idea of people telling stories about themselves and also having stories told about them. These stories can become constitutive on their experiences, that can either open up or limit the possibilities open to people." (6, p.9, line 8-13)*
Alternative stories	22	7	*"I think somebody's stories... and how they tell their story and how they can have conversations about their story, is the main place where change can happen." (3, p.16, line 10-18)*
Mapping Interpersonal relationships	5	4	*"What I tend to do, and this goes for anyone I work with, I do a genogram and a time-line... I am interested in what the past events were, what the current context is, what they want the future to be." (5, p.5, line 13-23)*
Identity and therapy	17	7	*"For the client they have a greater sense of contentment in who they are and a greater understanding of who they are and how they got there." (2, p.29, line 7-10)*
Helpful things	17	8	*"And the introduction of hope that they and their lives can be different. I think so often the systems that people end up in can be very disempowering and I think this is a very hopeful way of working." (2, p.29, line 10-14)* *"People who have been in systems a long time where there problems really aren't going to change and it is about having a different approach or story about that, a more hopeful story about that, I think it is important to give people hope." (7, p.15, line 18-22)*
Hope	8	4	*"I think all that is very helpful to give somebody the belief that they are somebody who can do things, so if they are somebody who can do things then they are somebody who can change things as well if they want to." (4, p.15, line 27-30)*

theme relates to what clinicians thought promoted change in therapy. This was considered to be identity and therapy leading to a richer understanding of the person. It is almost the result of the therapists approach to therapy, the client learning more about who they, discovering things about themselves and learning to be content with who they are.

3.4.3.3 ***Balancing Power in Therapy*** (For quotes illustrating this theme refer to table 3.4)

It seems that empowering the client is also a result of this approach to therapy; the client gains more control over their experiences and gains a sense of agency again. This links to being client-centre and respecting the client's expertise. The second way clinicians talked about balancing the power in therapy involves the therapist being critical of their role as a powerful person in the therapeutic relationship. The therapists acknowledge that and utilise their client centred ideas to redress this balance and empower their clients. This includes admitting that one can be wrong, suggesting things tentatively and working with the client's expertise. The clinicians also looked for people's solutions or resources, either that they had used in the past, which had been effective. Through doing this, the clinician is being respectful of the client having their own resources and having tried to resolve their own problems. Only four clinicians talked directly about this, but it is a theme implicit in redressing the balance in therapy and to being client-centred. Through 'redressing the balance' in the power relationships of therapy, it is hypothesised that this creates an environment in which change can occur. Previous research appears to lend support to this idea (Lysaker and Lysaker, 2001, 2002).

Table 3.4 Quotes regarding the theme: Balancing Power in Therapy

Lower Order Category	Number of quotes	Number of clinicians	Quotes
Empowering the client/Agency	11	4	*"For me that is not really important that their voices have gone, but that sense of 'I sent them packing'. Sometimes they will come up with an idea of how to address their voices, but will then say 'I did what you told me', and I say 'No, I just asked you what you would say, and you came up with it'." (3, p.20, line21-26)*
Looking for people's resources	5	4	*"As ideas come into my head 'I'm thinking this and that' 'what are your thoughts on that', inviting collaboration, I guess deconstructing the expert position really and not sitting there saying I am the expert on psychosis. I have ideas and experience, but they have ideas and experiences so, collaborating really and throwing my ideas and what I am hearing back to them for comments." (8, p.9, line 1-8)*
Powerful Therapist: redressing the balance	23	5	*"I am interested in the kinds of solutions that people use to get themselves out of a situation in order to feel better. I don't feel that is talked about much, I think the problem is mostly talked about and not asking for solutions to things." (1, p.7, line15-19)*

3.4.3.4 *Blocks to Therapy* (For quotes illustrating this theme refer to table 3.5)

The therapists talked about the blocks to therapeutic changes in terms of when they veered away from being client-centred or when there were factors outside of their control i.e., things outside of therapy or clients readiness. The theme of unhelpful things arose out from analysis of the data. Clinicians were critical of the narrative approach, as they were of other approaches. Most of the unhelpful things were around 'sticking to the model', relating to the previous theme of 'use of models'. Another suggested block to therapy was when the therapist's agenda came to the forefront. When this occurred the clinicians experienced the client disengaging. Linked to the therapist's agenda was the theme of the therapist as a member of society, which involved the therapist own biases as a person, separate to being a psychologist. This included having reactions to the unusual beliefs of their clients. This ties into being critical of their own approach and taps into how their own biases can affect how they are in therapy if they are unchecked. The final block to therapy that arose from the analysis of the data was societal blocks. Clinicians talked about therapy being only one part of people's lives and that if the rest of the messages they get are that they are ill, mad, bad, then it is a struggle to combat that with an hour of therapy a week.

Table 3.5 Quotes regarding the theme: Blocks to Change

Lower Order Category	Number of quotes	Number of clinicians	Quotes
Unhelpful things	9	4	*"I think sometimes the danger of this narrative work is that done badly, it can be this overly banal, everything is positive, you're a great person, what I call the culture of applause - once you have heard that once, you kind of want to hear something different really." (7, p.16, line 24-28)*
Therapist's Agenda:	6	3	*"It hasn't been helpful when I have misjudged what people want and they want more of the "you're an expert" [seeing therapist as the expert]." (1, p.13, line 1-3)*
Societal Blocks	5	4	*"When the systems around them are very powerful, then no matter how often you see them or how good the collaboration is, that is not enough, if you are trying to work individually." (3, p.22, line 24-27)*
Therapist as a member of society	6	4	*"When someone is holding onto beliefs that are pretty bizarre, I think it is pretty hard to sit with somebody holding those; you're feeling like screaming 'that's crazy, that's not happening'...there is a whole part of one's self that is not a therapist going 'rubbish, you're talking rubbish, stop these crazy thoughts' and that can be a very strong part." (3, p.17, line 19-26)*

3.5. Discussion

A grounded theory approach was used in order to explore the facilitators of change in narrative therapy. Four major themes arose from grounded theory analysis of the research data, which included: Style of the therapist, Agents of change, Balance of power and blocks to progress. Analysis of the data revealed the idea of a model of change in therapy that was not based upon a simplistic cause and effect model. The occurrence of change happens within a therapeutic and societal context.

The main style of the clinicians approach to therapy was to remain client-centred and to facilitate the client to be able to relate their own story, without the clinician imposing their own biases upon it. The importance of this factor in therapy is reflected in the existing research; particularly the benefits of staying client centred, not imposing one's own biases upon the client, and helping them build up an alternative story, or to make sense of the story they have got (Lysaker and Lysaker, 2002). Research carried out by O'Connor, Meaks, Pickering and Schuman (1997) into client's and families experience of narrative therapy highlighted that what clients found most helpful centred around having their experiences validated by the therapists and that they were treated as the experts in their own experience. The 'techniques' that the clients had found helpful were externalisation and "unique occurrences and alternative story. This reflects the elements highlighted by the clinicians.

Holma and Aaltonen (1997), suggest that a narrative style of therapy allows clients to rediscover their sense of agency and to reconstruct their life story. In the analysis of the clinicians' views of what can

facilitate change in therapy there is importance placed upon helping people to regain a sense of agency through empowerment and through techniques, which give the client control over their experiences. There was also a considerable emphasis on enabling the client to relate and consider more helpful alternatives to their current narrative.

Through redressing the balance in the power relationships of therapy, it is hypothesised that this creates an environment where change can occur. The current research appears to lend support to this idea. Holma and Aaltonen (1998) view that it is important that the person is viewed as an equal partner in the therapeutic conversations and to not let therapy be influenced by diagnostic stories. This was also cited by Lysaker and Lysaker (2002), as one of the factors that is helpful in allowing people to recover from psychosis.

3.6 Limitations

It is hoped that this study can add to the research on what aspects affect change when using a narrative style of therapy with clients experiencing psychosis. However, this research was based on the experiences of only eight clinicians whose interests were in a particular style of therapy, which was informed by a particular philosophy and obviously there is a danger in trying to generalise from such a select group. Also the author of this paper has a bias towards this approach to therapy and that will have had some influence over the data; although the author did take steps to limit the effect of this.

3.7 Future research and clinical implications

Currently, there is a need for utilisation of effective therapies within the area of psychosis. Following analysis of the research data, the author feels that an approach where the client and their experiences are of central importance when considering how to affect change in therapy. It is hoped that this research can provide a good starting point to consider how to advance the use of a narrative style of therapy with this population. Further research needs to be carried out addressing the client's views of the therapy process to highlight what they feel constitutes change in therapy. It would be helpful if a measure could be designed to detect change in therapy when adopting this approach which is not based upon more dominant theories of what constitutes change in terms of reduced reporting of psychotic experiences.

Analysis of the current research indicates that it is not of vital importance what techniques or models that are used in therapy. If therapists can absorb into their practice some of the ideas explored in this research, i.e., being client-centred and creating a non-hierarchical relationship, then it is possible that improvement can be obtained in the effectiveness of therapy with this client group. However, this is given with the obvious limitation that therapy is only one aspect of the influences upon the client and therefore any changes in therapy will be influenced by outside forces.

3.8 References

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Chapter IIII: Reflective Paper

The role of 'medical models' and 'psychological models' in the treatment of people who experience psychosis

Word count: 2049 (Excluding tables and References)

4.1 Introduction

My research thesis includes a literature review of the concepts of self in psychosis and the implications for clinical psychology, a grounded theory study exploring clinician's experience of using narrative therapy with people who experience psychosis, and further research exploring the facilitators of change in a narrative approach to therapy. The aim of this reflective paper is to explore some of the themes that arose out of all three papers and how they have impacted upon me. The paper will cover the following: the major themes arising from the research and my reflections on the research process and my future career

4.2 Themes arising from the research

4.2.1 Dominance of the 'medical model'

One of the themes that came out strongly in my main paper and the literature review was the dominance of the medical view of psychosis, particularly in regards to 'schizophrenia'. Psychosis within this model is seen as being a deficit within the person, characterised by 'symptoms' and a poor prognosis. This medicalisation of distress has its roots in how 'mental disorders' have been treated historically. Roe and Davidson (2005) comment on how throughout history there have been varying explanations for the type of behaviours seen in psychosis, ranging from witchcraft and bedevilment to our current concept of 'illness'. People who are considered to be 'psychotic' have a history of being treated badly in society and treatments have included Electroconvulsive therapy and Lobotomies (Roe and Davidson, 2005). Asylums were created to keep 'mad' people away from the rest of society and the physicians in charge of these asylums, were to become the discipline of 'psychiatry'. Moncrieff (1999) provides a history of treatments for mental disorders and stresses that Insulin

Coma Therapy was once regarded as a specific treatment for schizophrenia, and was probably the first treatment in common use. There was a high death rate from this treatment and patients were put into long comas, which probably caused brain damage. Moncrieff (1999) shows that prior to the 1950s, 'antipsychotics' or 'neuroleptics' were known as major tranquilizers and were used as chemical constraints. Moncrieff (1999) shows that the medical approach to schizophrenia has only really been dominant since the 1950s, this is when psychiatry claimed that psychiatric drugs had a therapeutic effect, as opposed to a sedative quality.

'Mental disorders' are now addressed with the same model applied to physical illness. Some of the elements of the 'illness model' include the following (Wade, & Halligan, 2004):

1. All illness and all symptoms and signs arise from an underlying abnormality within the body, referred to as a disease

2. All diseases give rise to symptoms, eventually if not initially, and although other factors may influence the consequences of the disease, they are not related to its development or manifestations.

3. The patient is a victim of circumstance with little or no responsibility for the presence or cause of the illness.

4. The patient is a passive recipient of treatment, although cooperation with treatment is expected.

Szasz (1997) thinks that to call psychological phenomena 'illnesses' is misleading because they share little in common with physical illness. `Mental illness' is not something a person has, it is something he does or is. Szasz (1997) suggests that physical illnesses, on the other hand, just happens to a patient, and cannot be cured by increasing self-knowledge and understanding.

I feel that the illness model is unhelpful in terms of providing a framework for understanding psychosis. In internalising the problem, and cutting it off from any meaningful context, people are left with very little agency over their experience. It is my view that this can lead to a sense of hopelessness in people who are accepting of the medical model. The medical model implies accepting that one is ill and that one needs to accept powerful drugs in order to 'get better'. I have no problem in recognising that the medical model can account for some people's experience of psychosis but I do have a problem with it being presented as the only option that people have. There also exists countless websites regarding 'schizophrenia', which represent it as being a medical condition.

4.2.2 Lack of impact of alternative explanations

Another theme that emerged from my research was looking at *alternative explanations* for people's experience of psychosis that are grounded in the person's experience and cultural contexts. Both the research base, and the clinician's experience of working with people experiencing psychosis, provides support for the role of experience in the development and maintenance of the psychosis. Table 4.1 represents a selection of the studies indicating support for alternative explanations for people's experiences.

Table 4.1 Studies representing alternative explanations.

	Studies
Role of Trauma	Read, J., van Os, J., Morrison, A.P., & Ross, C.A. (2005) Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavia,* 112:330-350. Kilcommons, A.M., & Morrison, A.P. (2005) Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors. *Acta Psychiatrica Scandinavia,* 112:351-359.
Role of Culture	Kirmayer, L.J. (2005) Culture, Context and Experience in Psychiatric Diagnosis. Psychopathology, 38:192-196.
Way of Coping	Prouty, G. (2004) The hallucination as the unconscious self. *Journal of the American Academy of Psychoanalysis,* 32(4):597-612.

However, throughout my Clinical Psychology training so far, psychosis has predominantly been presented as being an 'illness'. Psychology's role has been in treating the 'symptoms' of the problem, with psychiatry taking the lead in treating the 'cause'. Even within the area of narrative therapy where people's contexts are taken into consideration, people are still viewed as being ill.

I find it very disheartening, when I read articles criticising the dominance of the medical model; arguments which date back for as far as there has been a medical model. Yet, the medicalisation of distress still appears to be the dominant view of psychosis. It makes me realise the strength of current cultural views on how things are conceptualised. The concept of 'mental illness' is so prevalent, I do not think articles in journals will have the effect of changing the dominance of this particular model. We live in an age of media, which is heavily influential in the construction of concepts. It is probably through this media that a challenge could be made to this dominant concept. I think it also needs to be kept in mind that the medicalisation of distress has secondary gains for both psychiatry as a profession and to powerful drug companies who need to sell their products (Moncrieff, 1999).

4.2.3 Is psychosis a problem?

The final important theme from my research revolves around the concept of 'psychosis' being construed as the 'problem'. When looking at the research on psychosis, it is very much presented as being the problematic element that people are presenting with. I do not want to say that the experience of psychosis is not distressing, I have experience myself of night time hallucinations which are incredibly distressing, so I have some understanding of what they may feel like.

However, I do not get distressed about the fact I have these experiences because I know that they are part of a 'normal' condition and a culturally recognised as part of 'normal experience'. However, if my experiences were reflective of the fact that I was 'crazy', then I think my distress would be heightened.

In my career so far, most of the patients I have seen, especially those without psychosis, have either asked me if they were crazy or have thought at one time or another that they were going 'crazy'. This has been a distressing experience for them, but through normalisation in therapy they become less distressed by their experience. So imagine if a person is having experiences that are in themselves disturbing, but that person also knows that other people will think they are mad if they reveal them. This in turn would increase the distress. Rather than lacking insight, my experience of people who have psychotic phenomena know that other people think they are mad, but that their experience makes sense to them.

Some of the clinicians involved in my study thought the psychosis was a normal reaction to abnormal situations. So when it comes to therapy with people who experience psychosis, traditional therapies look predominantly at treating 'symptoms'. This includes challenging and finding evidence against the person's beliefs and experiences and encouraging people to accept that they are ill as an explanation for their experiences. Within the approach of the therapists, they look at understanding why someone has developed these experiences. Frequently this is due to a history of trauma, abuse and invalidating experiences. Therefore, the psychosis is seen as being secondary to the person's life experiences. Within this framework, psychosis can be viewed as an attempted solution to the person's distress, not necessarily the cause.

4.3 My reflections on my research and my future career

Prior to beginning this research I had very fixed views against the solely medical treatment of people, especially within psychosis. I thought that my way of understanding psychosis was better; therefore they had to be wrong. As a result of interviewing these clinicians I have learnt a lot about the principles of social constructionism and the critique of all approaches, not just the medical model. I have realised that my anti-psychiatry views were in fact more about the way in which the model has been presented as being 'the truth', and the effect this can have upon people. I have also learnt not to enforce my views onto anyone else, because if I am doing that, it makes me just as open to the criticism of thinking that I possess the 'truth'.

My initial hopes for this research project were to interview clients who had experiences of psychosis and an experience of a narrative approach to therapy. Unfortunately, I was unable to recruit enough participants to create a valid study. This appeared to be for two reasons. First, people who call themselves 'narrative therapists' do not get clients referred to them with psychosis. Second, there are not many clinicians using narrative techniques in their practice. The clinicians I was able to get to participate in my research had either recently changed jobs and therefore had not been working with clients for long enough, or they had moved to jobs where they were now no longer working with clients with psychosis. Although I was unable to carry out my original idea, I feel that the results of the projects I have submitted will be useful to have in the research pool. More importantly they have been incredibly helpful to me in giving me a language to express my view more eloquently and with less hostility.

In the future I want to work with people experiencing psychosis. My hopes have always been to influence a move away from the dominance of the medical model. This is still something I hope will focus in my career, but I am more mindful now of the powerful systems that clients are often being treated in and how careful I would have to be in trying to challenge those systems. It will not make much difference to my career if the medical model is not challenged, but I think it would make a positive difference to the lives of the people who are contained within the system and at the same time are incredibly disempowered by it. They need a chance to have a different way of understanding their experiences.

4.4 Conclusions

I carried out the research contained in this thesis because I believe that there are other ways of viewing psychosis, other than that offered in the medical model. I believe that a narrative style of approach, with the caveats provided by constructivist philosophy, enables people to construct there own meanings to the psychosis and that through the process they are empowered and have increased control over their difficulties. In this approach people have the option as the whether they want to learn to live along side the psychosis, or if they want to learn to eradicate this experience. The most important element is that the choice is theirs. There is nothing inherently wrong with psychotic experiences; the incidents of psychosis in the 'normal' population provide support for this. What is a problem is the distress that a person is presenting with and how psychosis is constructed in this society.

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Appendix 1

Ethical approval from Warwickshire Multi-Regional Ethics Committee

Warwickshire Local Research Ethics Committee
Recognised by COREC to review Type 2 MREC Applications
Lewes House
George Eliot Hospital
College Street
Nuneaton
Warwickshire
CV10 7DJ

Tel: 02476 865244
Fax: 02476 865264
pat.horwell@geh.nhs.uk

08 June 2005

Miss Deborah T Green
Trainee Clinical Psychologist
Coventry and Warwick University
School of Health and Social Sciences
Coventry University
Priory Street
CV1 5FB

Dear Miss Green

Full title of study: **The use of Grounded Theory approach to explore the experiences that adults with psychosis have of Narrative therapy.**
REC reference number: **05/Q2803/69**

Thank you for your application for ethical review, which was received on 01 June 2005. I can confirm that the application is valid and will be reviewed by the Ethics Committee at the meeting on 29 June 2005.

Meeting arrangements

The meeting will be held in the Ryton Organic Gardens (map enclosed) on 29 June 2005 at 2:00 p.m. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you are unable to attend the meeting the Committee will review the application in your absence.

The review of the application has been scheduled for 2.30 p.m. Would you please let me know whether or not you would be available to attend at this time.

Please wait in the foyer and you will be called into the meeting. I apologise in advance for any delay in reviewing your study on the day.

Documents received

The documents to be reviewed are as follows:

Document	*Version*	*Date*
Application		23 May 2005
Investigator CV		23 May 2005
Protocol	1	23 May 2005
Covering Letter		23 May 2005
Peer Review		11 December 2004
Interview Schedules/Topic Guides	1	23 May 2005
Participant Information Sheet s	1	23 May 2005

Participant Consent Form s	1	23 May 2005
Other		17 March 2005
Other		(None Specified)

No changes may be made to the application before the meeting. If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

Notification of the Committee's decision

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from the date of receipt, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

Site-specific issues

The application form indicates that the study does not require the appointment of local Principal Investigators responsible for the conduct of the protocol on each site. No site-specific assessments are therefore required locally and there is no need to inform Local Research Ethics Committees (LRECs) of the research.

The Committee will consider the "no local investigator" status of the study when carrying out the ethical review, and this will be confirmed when I write to you after the meeting. If the Committee decides that site-specific assessment is required, you would then need to arrange for Part C of the application form to be submitted to LRECs.

Management approval

All researchers and local research collaborators who intend to participate in this study at NHS sites should notify the R&D Department for the relevant care organisation and seek formal management approval. You should advise researchers and research collaborators accordingly. Where the researcher or collaborator does not have a substantive contract with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

The management approval process may take place at the same time as the ethical review. Final management approval from the care organisation will not be confirmed until after a favourable ethical opinion has been given by this Committee.

Further communication

All further communications from the Committee during the progress of this application will be solely with you as Chief Investigator. It is your responsibility to inform other researchers, the research sponsor and NHS care organisations of the progress of the review, as you think necessary. At the end of the review, the sponsor will be informed of the outcome.

05/Q2803/69 Please quote this number on all correspondence

Yours sincerely

Ms Pat Horwell
Administrator

Appendix 2

Participant Information Leaflet

(Empirical Paper 1 and 2)

Clinician Information Sheet

You are being invited to take part in a research study. Before you decided it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Why do people do research?

There are many reasons for doing research and evaluation. The most important reason is to ensure that mental health services are the best they can be. We need to find out what works particularly well, as well as what needs to change to improve services. One of the best ways of finding this out is to ask people what they think, usually by interview or questionnaire.

How does research happen?

Usually a researcher has an idea about what they want to explore. For example, a researcher might want to know "Does this therapy work?" or, "What is it about this therapy that works?" After deciding which areas to investigate, a researcher usually asks the people involved in the therapy to take part in the research. Those agreeing to take part are usually interviewed or given questionnaires with the aim of answering the research questions.

Do I have to take part?

No. You do not have to take part in any research and you do not have to give any reason for refusing. Just tell the researcher you do not want to take part. You can also withdraw at any time. If you decide that you do not wish to take part, after agreeing to do so, just tell the researcher you wish to withdraw from the research. Again you do not have to give any reasons why.

What will happen if I take part?

If you choose to take part in this research you will be asked to attend a research interview. The research interview should last for approximately 90 minutes. A further appointment will be arranged to enable you to discuss the research findings with the researcher. This appointment should last 60 minutes. During the initial visit by the researcher you will be asked a series of questions relating to your experience of your therapy sessions and the impact this may have had on your life. During the second interview you will be provided with feedback of the results of the research and you will be invited to add you own feedback.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks that can be identified by taking part in this research. However, if you do become distressed during, or after, the interview then steps will be taken to ensure that you are supported through this and given information about where you can access further support.

What are the possible benefits of taking part?

Your contribution to this research will provide a valuable insight into whether mental health services are providing effective services and also into how they can be improved. It will also provide useful information regarding the usefulness of narrative therapy for people who have psychotic experiences.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

What will happen to the information I give in interviews?

The information you give to me in the interviews is entirely confidential. The tapes of the interviews will be coded to ensure that they are anonymous and will be kept in a locked cabinet in a locked office and will be destroyed once the research is completed. The interviews will be transcribed and also saved onto a computer. No names will be held on the computer, as data will be coded to ensure confidentiality.

What will happen to the results of the research?

After the information has been collected and analysed, an initial summary will be written and sent out to all those who have taken part in the research. I will ask for feedback and will include comments in the final write up. Once the research has finished I hope to publish the results in a number of journals, as well as present the findings to those who have taken part in the research.

Who has reviewed this research?

The research was first reviewed by staff members of Coventry University in the form of a research proposal. An external examiner also approved it. Once this was approved, the research was then reviewed by the Warwickshire NHS Research Ethics Committee.

Supervisors

Academic Supervisor

Dr. Helen Liebling
Lecturer-Practitioner in Clinical Psychology
School of Health and Social Sciences
Coventry University
Priory Street
Coventry
CV1 5FB

Telephone: 02476 888328
E-mail: h.liebling@coventry.ac.uk

Clinical Supervisor

Dr. Maria Gennoy
Clinical Psychologist

E-mail: riagennoy@yahoo.co.uk

If you would like to discuss this research further, please contact me at:

Debbie Green
School of Health and Social Sciences
Coventry University
Priory Street
Coventry
CV1 5FB

Telephone: 02476 888328
Email: debitoni2104@hotmail.com

You will be given a copy of this information sheet and the signed consent form for you to keep. Thank you for taking part in this study.

Version: 2 Date: 8th August 2005

Appendix 3

Participant Consent Form

(Empirical Paper 1 and 2)

Clinician Consent Sheet

After reading the attached information sheet, please complete and sign the following form: (please initial the boxes)

☐	I have read and understood the Research Information Sheet.
☐	I understand that the interview will be tape-recorded for the purposes of being transcribed (typed) and I consent to being recorded.
☐	I understand that after the tape has been transcribed, the interview tapes will be erased.
☐	I understand that I can withdraw from the research at anytime, and that I do not have to give my reasons for doing so.
☐	I understand that findings from the research will be made public, but that identifying details will be removed from the data to ensure confidentiality.

Participant's Name:.....

Signed:..... Date:.....

Researcher's Name:.....

Signed:..... Date:.....

Version: 2 Date: 8th August 2005

Appendix 4

Semi-structured Interview Schedule

(Empirical Paper 1 and 2)

Clinician's Interview Schedule

1. **Why do you feel clients have psychotic experiences?**

2. **What role do you feel psychosis has for the client?**

3. **What part does the social and historical context of the person, do you feel, contributes to the development of their problem?**

   Suggested Prompts and follow on questions:

   a) Can you tell me more about that?
   b) Would you say that the primary focus of your is the client's current problem or the client themselves?
   c) What do you try to learn about the person?
   d) Can you describe the role, if any, of the meaning of psychotic experiences in the way you work.

4. **What is most important to you when taking a historical background?**

   Suggested Prompts and follow on questions:

   a) Are you interested in the meaning of the events that have shaped the person?

5. **Do you view psychosis as being an integral part of who that person is?**

6. **Have you worked with clients using a narrative approach?**

7. **What parts of narrative therapy do you use?**

   Suggested Prompts and follow on questions:

   a) Can you describe what you mean by narrative therapy?
   b) What part of the therapy that you use would be described as narrative?

8. **Can you tell me about the way you have worked within sessions?**

Suggested Prompts and follow on questions:

a) Can you tell me more about that?

b) What do you feel the aims are of what you are or were doing in sessions?

c) How have you gone/did you go about achieving these aims?

d) What do you remember about the sessions?

- What did you do in sessions?
- How do you begin?
- What kind of questions do you ask?

9. **What, if anything, have you found helpful about using this approach with psychosis?**

Suggested Prompts and follow on questions:

a) Can you tell me more about that?

10. **What, if anything, has been least helpful about using this approach with psychosis?**

Suggested Prompts and follow on questions:

a) Can you tell me more about that?

11. **What do you feel about the view of the psychologist as an expert?**

Suggested Prompts and follow on questions:

a) Do they view the therapeutic process as a voyage of discovery?

b) What is your approach?

c) How do you work with your clients?

12. **Is there anything else you would like to tell me about narrative therapy and/or psychosis?**

Appendix 5

Excerpt from Transcript (Empirical Paper 1 and 2)

Debbie: Why do you feel people have psychotic experiences?

P: It's different for every individual. The couple of people that I am working with at the moment, one of them was sexually abused as a child and I think her own understanding of her experiences of intrusive voices now, is that of a result of the abuse. The sort of things that she hears do sort of lend weight to that idea because they are of a sexual nature. I am almost saying why she thinks she has a psychotic experience. Trauma, I think could be a reason. Another person that I am working with who is being seen by a psychiatrist and social worker in the team, there is a question about whether she does experience intrusive thoughts/images or whether she is fabricating them. One hypothesis I have around that, it feels difficult saying this as it sounds as if I don't believe her either. One idea is that she describes herself as quite rebellious and her parents are social workers and it seems that it is part of her rebellion against the family background where madness is controlled, and she is rebelling against that by providing this madness where it is not wanted. In my own research I joined a mental health service walking group and quite a few people in it, who would be described as having enduring mental health problems, and within that who might be described as psychotic, or who would describe themselves as schizophrenic. It was interesting that a number of people, maybe that was something about this area, but there seemed to be that a few people had in common that those experiences seem to develop when they were under educational stress, so people who went to university. That the pressure of that got so much that they kind of dropped out. Then seemed to sort of deliberately take a different stand on life in that they didn't want to be part of that rat-race that caused them a lot of pressure. For

one guy, he said it was almost like a part of himself kind of was running away with itself. He was very philosophical and very into landscape and nature and being part of nature. That sort of thinking would sort of escalate to the point where he was completely mind-blown by the idea of infinity. That was one thing he really struggled with. He was really into rowing as well. And the pressure of sporting achievement at university as well added to it. He would get into the rhythm of rowing and would spark of thoughts about being in rhythm with the earth that would just get bigger and bigger. So that is an individual story, it's like an interaction between his experiences and his characteristics as an individual. It's a fine line as to where you would say something is psychotic or not. I'm not sure why that depression led to what led to psychosis.

Debbie: So what do you think of the idea that there is meaning in psychosis then?

P: That's quite interesting in line with what I was saying about the client that the team thought was fabricating her illness. The role it plays is it is a way of challenging the background/parents; it's like the ultimate challenge, which she could give to them. Sort of like you can't control this. This other lady I was talking about who was abused, the role of the psychosis, she sees it as something she has created, she feels that she has invented these voices. She experienced abuse by her uncle between the ages of 8-13 and then the uncle moved away so it stopped at that point. But also at that time her family were involved in the Mormon church then she got really involved in that herself and there was a lot in the family about who was involved and who wasn't. But to cope with

Appendix 6

List of Open Coding (Empirical Paper 1)

Open Coding: Empirical Paper One

	Category	Number of times used	Number of participants using category	Example
1	**Society's exertion of pressure through Roles and Standards**	20	7	"Young men/young women, that gender thing - so we know that men and boys find it more difficult to talk about emotional kind of things and so are less likely to seek help and there are higher suicide rates." (7, p.8, line 4-8) "That is linked to social roles and expectations of being in a relationship. (1, p.12, line 25-26)
2	**Cultural and Social Contexts**	23	8	"If in the culture, psychosis, people who hear voices, is revered or is totally benign, then I think that is a powerful force." (1, p.6, line 14-16)
3	**Differences in outcome**	7	5	"And then on all the work on outcome studies of psychosis, how outcome varies massively throughout the world. That in the west we have a way of making things worse for people." (6,p.2,line 2-5)
4	**Possible reasons for differences**	10	4	"In some cultures psychosis can be resolved very quickly because somebody who has it...would be seen as being somebody quite special, because they are experiencing things which are valued. People become valued for their experiences."(3, p.8,line 3-8)
5	**Family influences in psychosis**	10	4	"Often family members have been a part in that person developing that tendency for psychosis." (2, p.9, line 5-6)
6	**Social context of a person**	26	7	"When people develop psychosis, what is going on around us, in our social context, can help us or hinder us dealing with difficult situations." (2, p.5, line13-16)
7	**Client's Disempowerment**	7	4	"I think it is probably about disempowerment, feeling very separate from prevailing social norms. Being caught up under societal discourse." (1, page 1, line 4-6)

8	**Powerful Systems**	15	6	This woman has become involved with mental health services and on one hand the story I am giving you is her challenging control of madness, and yet on the other hand she is collaborating with services that are just like those parts of her family that are there to control madness." (5, p.4, line 27-31)
9	**Clients: expert by experience**	13	6	"Clients/service-user brings a whole load of things too, their own expertise as well and their own experience of themselves, so I think it is important to collaborate." (7, p.13, line 4-6)
10	**Questioning Medicalisation of distress**	18	7	"I wouldn't think it was my business to question that or to suggest that was a weird experience or part of an illness or something to be got rid of." (6, p.5, line 14-16)
11	**Medication: Limiting choices**	12	3	"[The medical model] gives people a reason never to change and it only gives them the option to change if it is the pill that did it. So it kind of limits who the choice belongs to." (3, p.21, line 13-16)
12	**Questioning Biological Influences**	7	4	"Now because we live in a kind of medical society I think it is a natural progression...that we have this thing called psychosis, people kind of get diagnosed and get medicated."(8,p.4,line 3-6)
13	**Questioning the eradication of perceived abnormalities**	15	7	"This madness is still seen as this thing that is terrible and has to be controlled, and more and more, all the psychiatric drugs and everything." (5, p.4-5, line 34-1)
14	**Alternatives explanations to medicalisation of distress**	29	6	"I suppose to start with, a lot of the experiences that people have that get called psychotic, they are normally distributed throughout the whole of the population so regardless of our explanations for them they are fairly common and they are fairly understandable really." (7, p.1, line 4-9)
15	**The effects of labelling**	24	4	"It's quite detaching of their identity. It's quite a thin conclusion about people, any kind of label." (1, p. 4, line 2-4)

16	**Questioning the utility of specific psychological/medical models**	26	8	"Psychologists have this desperate need to have models and I think that is to do with our need for professionalism, integrity and so called practitioner model". (2, p.12, line 7-10)
17	**Questioning the idea of one way of making sense/truth**	16	5	"People vary in their understanding of it some people take a very medical approach and some people are more into a psychological psychosocial approach." (7, p.4, line 18-20)
18	**Disconnection from society**	18	6	"A lot of the research… relates to how life experience relates to experiences of rejection and feelings of alienation." (4, p.2, line 5-8)
19	**Making Sense**	18	5	I think it can have a lot of meaning for people, I think it can provide meaning for their experiences." (8, p.5, line 3-4)
20	**Psychosis as attempted solutions to relieve pressure/distress/uncertainty**	28	8	"Rather than face the horror of what has happened, or face the internal conflict, it splits off so that however tormenting the voices, may be… it's easier than what could have been were the psychosis not to have happened." (3, p.5, line14-19)
21	**Ways of understanding psychosis:**	25	7	"If you talk about it in [religious, spiritual] ways it can enhance your identity or enhance positive experience of identity." (4, p.5, line 20-22)
22	**Abuse/trauma and psychosis**	19	8	"There is a growing body of evidence that suggests that people have psychotic experiences due to traumatic experiences they have had." (4, p.1, line17-19)
23	**Link between trauma and content of psychosis**	10	5	"The way I understand psychotic experiences is that they are formed by life experiences and things that have happened and if people have experienced traumas or difficult events." (8, p.1, line 4-7)

24	**Interpersonal Stresses**	10	5	"People who have become psychotic...have usually not had fantastically easy relationships with...family, parents, people in authority, schools." (2, p.1, line 10-12)
25	**Exploring meaning:**	17	7	"I think it is an essential thing to help that person to make sense of what is happening to them." (2, p.3, line 1-3)
26	**Opening up choice different perspectives:**	13	7	"There are a lot of choices that need to be made to get back to the middle ground and often needing to experience that worthlessness first, often for people that is not an option." (3, p.9, line 7-10)
27	**Externalisation**	26	7	"I keep separate people and their problem. Working around the ideas that the problem is not inside the client, the problem is about external forces I suspect." (1, p.4-5, line 34-2)
28	**Use of story**	18	7	"I think that gathering a person's story is far more important than gaining fact...it is the way they have made sense of the story, how they have constructed about themselves, the world and other people. (2, p.9, line 6-11)
29	**Alternative stories**	22	7	"Looking at those parts of the story that are important but that might have become drowned out by other parts. I try to get a fuller story I suppose." (5, p.6, line 26-29)
30	**Mapping Interpersonal relationships**	5	4	"I usually draw up a genogram. I'm interested in relationships that people are in, family relationships, but also relationships that aren't valued so much." (1, p.6, line 34-36).
31	**Looking for people's resources**	5	4	"I am interested to learn how people have learnt to deal with situations in the best way they can and who has been helpful in that process." (1, p.7, line 8-11)

32	**Client centred**	17	6	"I am trying to develop a shared understanding of their difficulties, what they are about, why they might have started and why they carry on." (6, p.4, line 2-4)
33	**Client's agenda**	15	8	"Initially I am interested in listening to what people have got to say. I don't go in there with a real set agenda of 'I have to know a certain set of information by session one'." (4, p.8, line 4-7)
34	**Written communications**	10	4	"After a few sessions or at the end of therapy just say a few lines about how I was impressed with how you dealt with this and saying you this kind of a person." (4, p.9, line 29-32)
35	**Transparency**	12	4	"I think it is important in terms of defining the relationship to start with to be as open as you can be about why you are working with the person." (2, p.13, line 1-3)
36	**Identity and therapy**	17	7	"I like to learn about who the client is and I suppose for the client to learn who they are, because in talking about themselves, they are learning about themselves. (2, p.6, line 30-33)
37	**Empowering the client/Agency**	11	4	"Nobody can tell them what they are, they are themselves and that this aspect of things is something we can take into account." (4, p.9, line 16-18)
38	**Unhelpful things**	9	4	"Sometimes I think we get too caught up in telling the big story that we get removed from the embodied quality of that person living their life." (5, p.6, line 30-32)
39	**Helpful things**	14	7	"Just by asking a question, it raises a possibility, the suggestion of things could be different." (3, p.20, line 35-36)
40	**Standing alongside**	8	4	"Standing alongside people rather that being against them of too professional."(1, p.8, line 10-11)

41	**Trust**	10	3	"People describe it as being a comfortable experience...nobody is trying to dive in there are remove things whilst you aren't looking, or even while you are looking and against your will." (2, p.19, line 10-14)
42	**Validation**	12	5	"You have to validate their experience i.e., if I was there, I might start to believe those things as well." (2, p.16, line 16-17)
43	**Hope**	8	4	"What I think would be more helpful is to be looking at these stories and these places of possible hope and ways that have been positive in the past and could be again or enhance, and then what needs to happen after that is the practice of something being different, a behavioural embodied experience of something different." (5, p.7, line10-14)
44	**Therapist's Agenda:**	6	3	"It hasn't been helpful when I have misjudged what people want and they want more of the "you're an expert" [seeing therapist as the expert]." (1, p.13, line 1-3)
45	**Societal Blocks**	5	4	"When the systems around them are very powerful, then no matter how often you see them or how good the collaboration is, that is not enough, if you are trying to work individually." (3, p.22, line 24-27)
46	**Client's Readiness:**	6	3	"If you start trying to get people to change things before you have even validated them, before you have even got a platform from which to operate, you are on to a losing streak really." (4, p.15, line 20-23)
47	**Narrative approach as meta-theory: a philosophy**	16	6	"I think [the narrative approach] is more my meta-theory; I could see someone without doing CBT or person-centred planning, but I can't do without a story in my head of how that person got to where they are or where they want to get to, what they want the next chapter to be." (3, p.18, line18-23)

48	**Therapist as a member of society**	6	4	"Often the other dynamic of angry parent/recalcitrant child is a well-worn path. So in terms of the pitfalls for the therapist that is one to be mindful of." (3, p.17, line16-18)
49	**Therapist not fitting in with the dominant view of mental health.**	18	6	"There is always that pressure that I worry I am being frivolous and what people think about what I am doing." (5, p.13, line 3-5)
50	**Therapist: Expert by experience**	19	6	"I think that we have some knowledge's, I think we have some ways of looking at things that can be helpful to people." (3, p.23, line 11-13)
51	**Powerful Therapist: redressing the balance**	23	5	"To be critical of what we are doing as well, how is what we are doing any less social control that a psychiatrist giving drugs. It's not really a lot different. " (5, p.13, line 21-23)
52	**Therapist feeling supported**	8	5	"I found it really helpful for liking people and connecting with people. I say that because I say what I feel confident about doing is connecting with people." (5, p.11, line 27-29)

Appendix 7

List of Axial Coding (Empirical Paper 1)

Lower Order Category	Core Category	Memo Notes
Society's exertion of pressure through Roles and Standards	Society and Cultural Context	There appears to be a feeling that the roles and standards expected in society can put people under pressure, and that this is a possible contributory factor in people developing psychosis. So the pressure is about struggling to meet up to these expectations.
Cultural and Social Contexts	Society and Cultural Context	This category suggests that psychosis can be viewed differently depending on the prevailing culture. Within our culture it is predominantly medicalised but in other cultures it can be more valued. This appears to link to why outcomes are so poor in this country and to the medicalisation of distress.
Differences in outcome	Society and Cultural Context	Most of the clinicians talked about differences in outcome between the West and the developing world. This highlight the importance of the prevailing views regarding psychosis in the outcome for the person. This seems to link to alternative ways of viewing psychosis and that there is not just one way.
Possible reasons for differences	Society and Cultural Context	Gives possible reasons for the difference between cultures and states the importance of social factors such as family units and social roles - this links with what the clinicians were saying about the pressure of meeting expectations in this society.
Family influences in psychosis	Society and Cultural Context	This category links to the individualisation of distress, in that it looks at the role of the family in people developing difficulties. This links with theories of attachment and the role of the family in the development of psychopathy.

Social context of a person	Society and Cultural Context	As well as the broader category of social and cultural people seemed to be talking about taking into account people's more local context and their history. People talk about this in terms of how these are influential in people developing psychosis and how they affect the outcome.
	Society and Cultural Context	This whole category seems to be saying that there is this possibly thing called 'psychosis', but that it is inextricably linked to the context in which people are living. Both in the development of the psychosis and in the outcome. The things that seem to be important and family support and community support, In communities where they have this, outcome appears to be better. This is supported by the research.
Client's Disempowerment	Power	This category links to the social context; in that context people experiencing psychosis there appears to have been a disempowerment before the occurrence of psychosis. Link this with powerful systems and the effects of the dominant medical model, people are further disempowered.
Powerful Systems	Power	Within this category, people talk about the power of this systems that people get drawn into if they come into contact with mental health services and professionals. On the whole, the philosophy of these services, serves to further disempower people.
Clients: expert by experience	Power	After talking about powerful systems, the clinicians explicitly talk about viewing the client as having expertise in knowing themselves, and what it is to have these experiences. They seem to say that this knowledge should be respect and valued.
	Power	There seems to be a feeling that disempowerment plays a role in someone developing psychosis and that they then become further disempowered, What was important to the clinicians was to respect the clients expertise and this links to how the clinicians interact with the clients in therapy.

Questioning Medicalisation of distress	Questioning Reductionism	There appears to be a questioning of the dominance of the medical model and its limited ability to make sense of psychosis. They talk about pathologising people which goes against how the clinicians view psychosis in relation to being in a social context. The medicalisation of distress in a direct contradiction of how clinicians view people's experiences.
Medication: Limiting choices	Questioning Reductionism	The clinicians talk about medication in terms of the limitations is can put upon people's thinking and the options they have around how they view their experiences. This again relates to the social context and how medication in a dominant treatment. This is also linked to eradication, i.e., medications are designed to eradicate these experiences. Again this goes against what clinicians talk about in terms of trying to understand the meaning of these experiences.
Questioning Biological Influences	Questioning Reductionism	This more directly questions the validity of the biological influences in psychosis. The view of the clinicians appears to be that brain chemistry can be affected by our experience which again relates to the social context.
Questioning the eradication of perceived abnormalities	Questioning Reductionism	Dominant in the medical model is the eradication of 'psychotic symptoms'. There is a questioning of this from the majority of the clinicians on whether eradication works and on how psychosis is seen as 'bad'. Again this limits people's choice in how they want to view their experiences.
Alternatives explanations to medicalisation of distress	Questioning Reductionism	In this category suggestions are offered as alternatives to the eradication of 'symptoms'. As a whole these seem to be implying that psychosis can be seen as on a continuum of normal experience. Linking with other areas it suggests that there is a fine line between what is 'psychotic' and what isn't and that usually it is someone's distress that brings them in contact iwht services and not the actual psychosis.

The effects of labelling	Questioning Reductionism	This category looks at the effects of being in the mental health system or of the effects of being labelled 'psychotic' in this culture. The effect seems that people are reduced to that label i.e., they are a psychotic or a schizophrenic. It is suggested in this category and in others that this can influence outcome as people label themselves as psychotic, which can reduce people's options.
Questioning the utility of specific psychological/medical models	Questioning Reductionism	There seems to be a united opinion that the use of any model in a prescriptive way, is not a good thing. Linking to clinicians metatheory or philosophy, they do not reject any explanation or model, they view that used in the right way it doesn't matter what model you use. But if you are using any model in a prescriptive way, including the narrative model, then this is going against what works best for the client, which appears to be fundamental.
Questioning the idea of one way of making sense/truth	Questioning Reductionism	This model links to the ideas around the use of models, but talks about how one-way is presented as the answer to psychosis and that one-way is presented as the truth. Whether that be 'CBT for psychosis' or medication. Again, this is linked to the clinicians philosophy surrounding social construction ideas of there being multiple options.
	Questioning Reductionism	This category looks at the influence of a medical approach to psychosis, where treatment of choice is eradication of symptoms. This contradicts therapists views surrounding the development and maintenance of psychosis as relating to experience and to society, therefore internalisation of problems appears to ignore these influences. This contrasts with the many alternatives offered by the clinicians as to why people might develop psychosis.
Disconnection from society	Possible ways of understanding psychosis: opening up	The participants suggest that there appears to be a disconnection from society, that people who go on to have psychosis, experience. This is then followed by further disconnection because of their experience, and finally if they are in contact with mental health services, or hospitalised, this further separates people from society. This links to the research into recovery and on adolescents where re-establishing connections is key.

Making Sense	Possible ways of understanding psychosis: opening up	It is hypothesised the one of the roles of psychosis is to make sense of what has gone on for people or what is going on for people currently. People know something isn't quite right, and the psychosis helps to make sense of that, even if the psychosis is disturbing. This making sense is also linked to the social context in that we can only make sense of things in ways that are open to us. If we don't have any friends and things are crap at work, then we are limited in who we can check things out with. This also links to the disconnection that people experience prior to experiencing psychosis.
Psychosis as attempted solutions to relieve pressure/distress/uncertainty	Possible ways of understanding psychosis: opening up	This category explores the idea that psychosis is the person's attempted solution, which may have been useful at some point in time, but is not currently. The themes that came up were around relieving pressure, distress and uncertainty. This links to the social context in terms of the pressure people feel under to be a certain way. It also links to the ideas around the link between trauma and psychosis, that psychosis is a result of, or a way of coping ,with that abuse.
Ways of understanding psychosis:	Possible ways of understanding psychosis: opening up	This category links with the alternatives to the medicalisation of distress, and reflects the philosophy of the clinicians in that many explanations are considered and that this is in line with what the client brings to the table, in their way of understanding their experience. It includes medical, psychological and spiritual ways of understanding psychosis. Again this is contradictory to the dominant model in understanding psychosis.
Abuse/trauma and psychosis	Possible ways of understanding psychosis: opening up	The role of abuse or trauma was something all of the clinicians thought was important and it is supported by the research. They all had a lot of experience of the people they were working with having histories of abuse or trauma.
Link between trauma and content of psychosis	Possible ways of understanding psychosis: opening up	As well as trauma being a possible reason for why people experience psychosis, clinicians also had experience of the content of psychosis being reflective of people's experience. This links to other themes around the meaning in psychosis.
Interpersonal Stresses	Possible ways of understanding psychosis: opening up	Some of the clinicians looked at the role of interpersonal stresses in the formation of psychosis, both in childhood and currently. They involve bullying, lack of relationships or poor relationship and educational stress.

	Possible ways of understanding psychosis: opening up	This category looked at alternative ways of understanding psychosis. These reasons came out of the experience clinicians had of working with people with psychosis. There seemed to be a common theme of the longer you work with people with psychosis, the more you see the meaning behind it. This leads people to question the medical model as this goes against the clinicians experience of working with people.
Exploring meaning:	Specific and Non-Specific Aspects of Therapy	One of the things that the clinicians talked about doing with clients, links with their understanding of psychosis, and looks at exploring the meaning behind the psychosis. This is going against the eradication model, and the clinicians are not focusing on getting rid of the experiences, just understanding them. This links with the there of client's gaining a richer understanding of themselves as a result as therapy. And also links with developing a richer story.
Opening up choice different perspectives:	Specific and Non-Specific Aspects of Therapy	Much of the medical model is about limiting choices i.e., compulsory medication, the insight model. Much of the therapy done in this approach is about opening up choices and offering different perspectives. Giving people the choice of what they want to do. This links with the themes of being client centred and also redressing the balance in therapy because the therapist is aware of offering choices in a tentative way, and not claiming that they know the right answer.
Externalisation	Specific and Non-Specific Aspects of Therapy	Externalisation links with stories and alternative stories as being the most recognisable narrative technique that the clinicians were using. Externalisation was one of the key things that people used, not just as a techniques, but as a way of understanding how people relate to their experiences and using that language outside of sessions as well. Externalisation is one of the techniques that clinicians and find useful. This links in with the individualisation of distress found within the medical model, where problems are located in the person. Through externalisation, people's choices are opened up again as they have a relationship with their experiences

Use of story	Specific and Non-Specific Aspects of Therapy	Using people's stories was one of the more typical narrative techniques employed by most of the clinicians. The use of the clients story links to being client centred and also to the understanding that there is a social and historical context to the person and through understanding that, you can help the person to understand their experiences. Again the story idea is based upon social constructionist ideas of their being multiple realities and therefore the client's version of their story is the important one. The reflects the theme of there only being one way, one answer in the medical model. It is about helping clients t build up their story through using reflecting and tentative hypothesising.
Alternative stories	Specific and Non-Specific Aspects of Therapy	The alternative story again links to the idea that there is not just one version of somebody's story, and by using exploring you can unlock other stories that may have been buried
Mapping Interpersonal relationships	Specific and Non-Specific Aspects of Therapy	This probably links to building up a story and that the person exists within a context, getting a history of their family life and using the genogram to explore relationships.
Looking for people's resources	Specific and Non-Specific Aspects of Therapy	This seems to link to being client centred and respectful of the client having their own resources. Only four clinicians talked directly about this, but it is a theme implicit in empowerment, psychosis as a solution and client centred philosophy.
Client centred	Specific and Non-Specific Aspects of Therapy	The notion of being client centred is central to the therapy that is carried out. Even though people use narrative ideas, it is always with the proviso of what is best for the client. Through being truly client-centred they are also aware of critiquing their own practice and psychology in general which is reflected in the critique of models and some on the unhelpful things about therapy. Again this reflects the philosophy of the clinicians, those social constructionist ideas about nobody possessing the truth and there being many realities. It is also reflected in the research the benefits of staying client centred and not imposing your biases upon the client, but to help them build up an alternative story, or to make sense of the story they have got, in their own way.

Client's agenda	Specific and Non-Specific Aspects of Therapy	Relates to the above, but this is just reflective of how the clients set the agenda for sessions and not the therapist. The story is built up around what the client choose to talk about, and doesn't follow a structured assessment format, as used in other approaches. The clinicians also talk about how it can be difficult anyway to try and use a structured approach with people experiencing psychosis.
Written communications	Specific and Non-Specific Aspects of Therapy	Writing therapeutic letters is something some therapists talked about. But they also talked about it in terms of their general note writing and in reports, they talked about these in terms of being open and transparent when writing things about the client. This links to being client centred and to the theme of being transparent. It also again links to the over riding philosophy of the therapists, that this approach is not just about how you are in sessions, it extends outside of that i.e., so reports for other professional as well.
Transparency	Specific and Non-Specific Aspects of Therapy	This links to being client centred and also links to the over riding philosophy of the therapists, that this approach is not just about how you are in sessions, it extends outside of that to how you are with colleagues as well. Also that transparency is about being open to being criticised as you are not the one who has the truth.
Identity and therapy	Specific and Non-Specific Aspects of Therapy	It seems that a richer understanding is almost the result of this approach to therapy, the client learning more about who they, discovering things about themselves and learning to be content with who they are. This links to there being a context to the person and their experience.
Empowering the client/Agency	Specific and Non-Specific Aspects of Therapy	It seems that empowerment is also a result of this approach to therapy, the client gains more control over their experiences and gain a sense of agency again. This links to being client centred and respecting the clients expertise. Again the research points to the importance of agency in people who experience psychosis and research has shown that therapy can help people to regain their sense of agency and that appears to be reflected in what the clinicians have said.

Helpful things	Specific and Non-Specific Aspects of Therapy	Relates to some of the techniques clinicians have found helpful and also what the clients have found helpful. It seems that they like the approach because it fits with their philosophy.
Standing alongside	Specific and Non-Specific Aspects of Therapy	Elements of the therapeutic alliance, which is possibly achieved through being client centred.
Trust	Specific and Non-Specific Aspects of Therapy	Elements of the therapeutic alliance, which is possibly achieved through being client centred.
Validation	Specific and Non-Specific Aspects of Therapy	Elements of the therapeutic alliance, which is possibly achieved through being client centred. Linked also to client as expert, validating the clients experience and listening to their story..
Hope	Specific and Non-Specific Aspects of Therapy	Elements of the therapeutic alliance, which is possibly achieved through being client centred. Also an element that possibly inspires change?
	Specific and Non-Specific Aspects of Therapy	People's style in therapy relates heavily to their philosophy on the world, i.e., social-constructionist ideas around multiple realities and the influence of society upon the person's construction o themselves. Central to the therapy is the notion of being client centred; having that enables the clinician to utilise techniques in a way that is respectful to the client's understanding and true to their over riding philosophy. They remain critical of their own approach which again is guided by their philosophy.
Narrative approach as meta-theory: a philosophy	Clinicians Philosophy	As is clear throughout the themes the metatheory or philosophy of the therapist is a key component and guides the importance of the social context and the more critical view of specific approaches, including their own. Because of this philosophy they are more client-centred and critical of their own practice and suggestions in therapy. It is possible that through this approach the client is enabled to build a good relationship with the therapist which could be the catalyst for change. Research has suggested the importance of the relationship and service-user led research and highlighted being listened to and respected and believed as being important in their recovery.

Therapist as a member of society	Clinicians Philosophy	This ties into being critical of their own approach and taps into how their own biases can affect how they are in therapy. After all the are a member of this society.
Therapist not fitting in with the dominant view of mental health.	Clinicians Philosophy	Because their view is so opposite to the medical model it can cause some difficulties in mental health settings. However due to their overarching philosophy they extend the same values to their colleagues and are transparent and respectful of other people's models. So although they know they are different, people do not challenge their way of working.
Therapist: Expert by experience	Clinicians Philosophy	This is again related to not necessarily having the right answer, but respecting that you have got some expertise, particularly in the experiences of meeting lots of people with similar problems and in being able to have conversations with people and to build up that rapport.
Powerful Therapist: redressing the balance	Clinicians Philosophy	The therapist is a powerful person in the relationship. The therapists acknowledge that and utilise their client centred ideas to redress this balance and to empower the clients. This includes admitting you can be wrong, suggesting things tentatively and working with the client's expertise.
Therapist feeling supported	Clinicians Philosophy	In order to cope with possibly being in a hostile environment, the clinicians have found it helpful to have the support of people who share similar ideas or who can offer them support.
	Clinicians Philosophy	Some of the experiences of the therapist mirrors that of the clients in not matching up to what people expect, feeling marginalized and somewhat disempowered. However their over riding philosophy seems to protect them from being told they cannot work in that way. However many of the clinicians stated that they did not feel that many people know what they did in therapy and were expected to be doing CBT.

Appendix 8

List of Open Coding (Empirical Paper 2)

Open Coding: Empirical paper two.

	Lower Order Category	Number of quotes	Number of clinicians	Quote
1	**Exploring meaning:**	18	7	"I think it is an essential thing to help that person to make sense of what is happening to them." (2, p.3, line 1-3)
2	**Opening up choice different perspectives:**	13	7	"There are a lot of choices that need to be made to get back to the middle ground and often needing to experience that worthlessness first, often for people that is not an option." (3, p.9, line 7-10)
3	**Externalisation**	26	7	"I keep separate people and their problem. Working around the ideas that the problem is not inside the client, the problem is about external forces I suspect." (1, p.4-5, line 34-2)
4	**Use of story**	18	7	"I think that gathering a person's story is far more important than gaining fact…it is the way they have made sense of the story, how they have constructed about themselves, the world and other people. (2, p.9, line 6-11)
5	**Alternative stories**	22	7	"Looking at those parts of the story that are important but that might have become drowned out by other parts. I try to get a fuller story I suppose." (5, p.6, line 26-29)
6	**Mapping Interpersonal relationships**	5	4	"I usually draw up a genogram. I'm interested in relationships that people are in, family relationships, but also relationships that aren't valued so much." (1, p.6, line 34-36).
7	**Looking for people's resources**	5	4	"I am interested to learn how people have learnt to deal with situations in the best way they can and who has been helpful in that process." (1, p.7, line 8-11)
8	**Client centred**	17	6	"I am trying to develop a shared understanding of their difficulties, what they are about, why they might have started and why they carry on." (6, p.4, line 2-4)

9	**Client's agenda**	15	8	"Initially I am interested in listening to what people have got to say. I don't go in there with a real set agenda of 'I have to know a certain set of information by session one'." (4, p.8, line 4-7)
10	**Written communications**	10	4	"After a few sessions or at the end of therapy just say a few lines about how I was impressed with how you dealt with this and saying you this kind of a person." (4, p.9, line 29-32)
11	**Transparency**	13	4	"I think it is important in terms of defining the relationship to start with to be as open as you can be about why you are working with the person." (2, p.13, line 1-3)
12	**Identity and therapy**	17	7	"I like to learn about who the client is and I suppose for the client to learn who they are, because in talking about themselves, they are learning about themselves. (2, p.6, line 30-33)
13	**Empowering the client/Agency**	11	4	"Nobody can tell them what they are, they are themselves and that this aspect of things is something we can take into account." (4, p.9, line 16-18)
14	**Unhelpful things**	9	4	"Sometimes I think we get too caught up in telling the big story that we get removed from the embodied quality of that person living their life." (5, p.6, line 30-32)
15	**Helpful things**	17	8	"Just by asking a question, it raises a possibility, the suggestion of things could be different." (3, p.20, line 35-36)
16	**Standing alongside**	9	4	"Standing alongside people rather that being against them of too professional."(1, p.8, line 10-11)
18	**Validation**	14	4	"You have to validate their experience i.e., if I was there, I might start to believe those things as well." (2, p.16, line 16-17)

19	**Hope**	8	4	"What I think would be more helpful is to be looking at these stories and these places of possible hope and ways that have been positive in the past and could be again or enhance, and then what needs to happen after that is the practice of something being different, a behavioural embodied experience of something different." (5, p.7, line10-14)
20	**Therapist's Agenda:**	6	3	"It hasn't been helpful when I have misjudged what people want and they want more of the "you're an expert" [seeing therapist as the expert]." (m, 1, p.13, line 1-3)
21	**Societal Blocks**	5	4	"When the systems around them are very powerful, then no matter how often you see them or how good the collaboration is, that is not enough, if you are trying to work individually." (3, p.22, line 24-27)
22	**Client's Readiness:**	6	3	"If you start trying to get people to change things before you have even validated them, before you have even got a platform from which to operate, you are on to a losing streak really." (4, p.15, line 20-23)
23	**Therapist as a member of society**	6	4	"Often the other dynamic of angry parent/recalcitrant child is a well-worn path. So in terms of the pitfalls for the therapist that is one to be mindful of." (3, p.17, line16-18)
24	**Powerful Therapist: redressing the balance**	23	5	"To be critical of what we are doing as well, how is what we are doing any less social control that a psychiatrist giving drugs. It's not really a lot different. " (5, p.13, line 21-23)

Appendix 9

List of Axial Coding (Empirical Paper 2)

Lower Order Category	Higher Order Category	Memo notes
Exploring meaning:	Style in therapy: Client-Centred	One of the things that the clinicians talked about doing with clients, links with their understanding of psychosis, and looks at exploring the meaning behind the psychosis. This links with the there of client's gaining a richer understanding of themselves as a result as therapy. And also links with developing a richer story. But it is more about the style they take in therapy rather than a technique. It is linked to being client-centred as it is about understanding the client in their context.
Opening up choice different perspectives:	Style in therapy: Client-Centred	Much of the style of this therapy is about opening up choices and offering different perspectives. Giving people the choice of what they want to do. This links with the themes of being client centred and also redressing the balance in therapy because the therapist is aware of offering choices in a tentative way, and not claiming that they know the right answer.
Transparency	Style in therapy: Client-Centred	This links to being client centred. This links to balancing the power in therapy as by being transparent you are being open to being criticised as you are not the one who has the truth
Client centred	Style in therapy: Client-Centred	The notion of being client centred is central to the therapy that is carried out. Even though people use narrative ideas, it is always with the proviso of what is best for the client. Through being truly client-centred they are also aware of critiquing their own practice and psychology in general which is reflected in the blocks to therapy. It is also reflected in the research the benefits of staying client centred and not imposing your biases upon the client, but to help them build up an alternative story, or to make sense of the story they have got, in their own way.
Client's agenda	Style in therapy: Client-Centred	Relates to the above, but this is just reflective of how the clients set the agenda for sessions and not the therapist. The story is built up around what the client chooses to talk about, and doesn't follow a structured assessment format, as used in other approaches.

Written communications	Style in therapy: Client-Centred	Therapeutic letters can be part of the techniques that are common in narrative therapy. But what the clinicians appeared to be saying was that they applied their client-centred style of therapy to their written communication as well; thinking more about reports and writing of therapy notes as opposed to therapeutic letters. Though clinicians did talk about using therapeutic letters.
Standing alongside	Style in therapy: Client-Centred	Elements of the therapeutic alliance, which is possibly achieved through being client centred.
Validation	Style in therapy: Client-Centred	Elements of the therapeutic alliance, which is possibly achieved through being client centred. Linked also to client as expert, validating the clients experience and listening to their story.
	Style in therapy: Client-Centred	
Externalisation	Agents of change	Externalisation links with stories and alternative stories as being the most recognisable narrative technique that the clinicians were using that appeared to produce a change in the narrative. It appears that through externalisation, people's choices are opened up again as they have a relationship with their experiences. This relates to the theme of choice or different perspectives in style of therapy.
Use of story	Agents of change	Using people's stories was one of the more typical narrative techniques employed by most of the clinicians. The use of the client's story links to being client-centred as it looks a the client's way of constructing their past. It appears to be about helping client's to build up their story through using reflecting and tentative hypothesising.

Alternative stories	Agents of change	The alternative story again links to the idea that there is not just one version of somebody's story, and by using exploring you can unlock other stories that may have been buried and help people to build a more helpful construction of themselves and their experiences.
Mapping Interpersonal relationships	Agents of change	This probably links to building up a story and that the person exists within a context, getting a history of their family life and using the genogram to explore relationships.
Identity and therapy	Agents of change	It seems that a richer understanding is almost the result of this approach to therapy, the client learning more about who they, discovering things about themselves and learning to be content with who they are. It links to the use of story and opening up choice; the result being the person learns more about themselves and that this is found to be helpful.
Helpful things	Agents of change	Relates to some of the components of therapy that the clinicians have found helpful in producing change, and also what the clients have found helpful. These relate to offering different perspectives, doing things outside of therapy and the flexibility offered by the approach.
Hope	Agents of change	Elements of the therapeutic alliance, which is possibly achieved through being client centred. Also an element that possibly inspires change?
	Agents of change	Clinicians talked about things that appear to bring some change in the person's narrative. But it appears that these changes occur within the context of a trusting relationship that is inherently client-centred
Empowering the client/Agency	Balancing Power in Therapy	It seems that empowerment is also a result of this approach to therapy, the client gains more control over their experiences and gain a sense of agency again. This links to being client centred and respecting the client's expertise. Again the research points to the importance of agency in people who experience psychosis and research has shown that therapy can help people to regain their sense of agency and that appears to be reflected in what the clinicians have said.

Looking for people's resources	Balancing Power in Therapy	This seems to link to being client centred and respectful of the client having their own resources. Only four clinicians talked directly about this, but it is a theme implicit in redressing the balance in therapy and to being client-centred
Powerful Therapist: redressing the balance	Balancing Power in Therapy	The therapist is a powerful person in the therapeutic relationship. The therapists acknowledge that and utilise their client centred ideas to redress this balance and to empower the clients. This includes admitting you can be wrong, suggesting things tentatively and working with the client's expertise.
	Balancing Power in Therapy	Through redressing the balance in the power relationships of therapy, it is hypothesised that this creates an environment in which change can occur. The research appears to lend support to this idea.
Unhelpful things	Blocks to Change	Clinicians talked about the elements of the therapy that they found to be unhelpful and possibly blocking of change. Most of the unhelpful things were around 'sticking to the model', relating to the previous theme of use of models.
Therapist's Agenda:	Blocks to Change	People talked about things that put up blocks to change, including when their own agenda got in the way. The experience of that is the client disengages.
Societal Blocks	Blocks to Change	Therapy is only one part of people's lives and if the rest of the messages they get are that they are ill, mad, bad, then it is a struggle to combat that. Therefore, creating change in therapy is affected by what else is going on in their lives.
Therapist as a member of society	Blocks to Change	This ties into being critical of their own approach and taps into how their own biases can affect how they are in therapy. After all the are a member of this society.
	Blocks to Change	The therapists talked about the blocks to changed in terms of when they veered away from being client-centred or when there were factors outside of their control i.e., things outside of therapy or clients readiness.

Appendix 10

Notes to contributors: British Journal of Clinical Psychology

Notes for Contributors

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
- Brief reports and comments.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at **http://bjcp.edmgr.com** .

First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN.

(You do not need to re-register if your status changes e.g. author, reviewer or editor).
Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

- Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author - **Editorial Manager Title Page for Manuscript Submission**
- Abstract
- Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - **Editorial Manager - Tutorial for Authors**
Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions: **British Journal of Clinical Psychology - Structured Abstracts Information**
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA (**http://www.apastyle.org**).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct - **Code of Conduct, Ethical Principles and Guidelines**
Principles of Publishing - **Principle of Publishing**

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication for easy and cost-effective dissemination to colleagues.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.
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